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CANADA HEALTH ACT

Public Administration Comprehensiveness Universality Portability Accessibility

ANNUAL REPORT
2011–2012

Canada

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INTRODUCTION

Canada has a predominantly publicly financed and administered health care system. The Canadian health insurance system is achieved through 13 interlocking provincial and territorial health insurance plans, and is designed to ensure that all eligible residents of Canadian provinces and territories have reasonable access to medically necessary hospital and physician services on a prepaid basis, without charges related to the provision of insured health services.

The Canadian health insurance system evolved into its present form over more than five decades. Saskatchewan was the first province to establish universal, public hospital insurance in 1947 and, ten years later, the Government of Canada passed the *Hospital Insurance and Diagnostic Services Act* (1957), to share in the cost of these services with the provinces and territories. By 1961, all the provinces and territories had public insurance plans that provided universal access to hospital services. Saskatchewan again pioneered by providing insurance for physician services, beginning in 1962. The Government of Canada enacted the *Medical Care Act* in 1966 to cost share the provision of insured physician services with the provinces and territories. By 1972, all provincial and territorial plans had been extended to include physician services.

In 1979, at the request of the federal government, Justice Emmett Hall undertook a review of the state of health services in Canada. In his report, he affirmed that health care services in Canada ranked among the best in the world, but warned that extra-billing by doctors and user fees levied by hospitals were creating a two-tiered system that threatened the universal accessibility of care. This report, and the national debate it generated, led to the enactment of the *Canada Health Act* in 1984.

The *Canada Health Act* is Canada's federal health insurance legislation and defines the national principles that govern the Canadian health insurance system, namely, public administration, comprehensiveness, universality, portability and accessibility. These principles are symbols of the underlying Canadian values of equity and solidarity.

The roles and responsibilities for Canada's health care system are shared between the federal and provincial/territorial governments. The provincial and territorial governments have primary jurisdiction in the administration and delivery of health care services. This includes setting their own priorities, administering their health care budgets and managing their own resources. The federal government, under the *Canada Health Act*, sets out the criteria and conditions that must be satisfied by the provincial and territorial health insurance plans for provinces and territories to qualify for their full share of the cash contribution available to them under the federal Canada Health Transfer.

On an annual basis, the federal Minister of Health is required to report to Parliament on the administration and operation of the *Canada Health Act*, as set out in section 23 of the Act. The vehicle for so doing is the Canada Health Act Annual Report. While the principal and intended audience for this report is Parliamentarians, it is a public document that offers a comprehensive report on insured health services in each of the provinces and territories. The annual report is structured to address the mandated reporting requirements of the Act; as such, its scope does not extend to commenting on the status of the Canadian health care system as a whole.

Provincial and territorial health care insurance plans generally respect the criteria and conditions of the *Canada Health Act* and many exceed the requirements of the Act. However, when instances of possible non-compliance with the Act arise, Health Canada's approach to the administration of the Act emphasizes transparency, consultation and dialogue with provincial and territorial health care ministries. The application of financial penalties through deductions under the Canada Health Transfer is considered only as a last resort when all other options to resolve an issue collaboratively have been exhausted. Pursuant to the commitment made by premiers under the 1999 Social Union Framework Agreement, federal, provincial and territorial governments (except Quebec) agreed through an exchange of letters, in April 2002, to a Canada Health Act Dispute Avoidance and Resolution (DAR) process. The DAR process was formalized in the First Ministers' 2004 Accord. Although the DAR process includes dispute resolution provisions, the federal Minister of Health retains the final authority to interpret and enforce the *Canada Health Act*.

In 2011–2012, the most prominent concerns with respect to compliance under the *Canada Health Act* remained concerning patient charges for medically necessary services in private clinics, and queue jumping. Health Canada has made these concerns known to the provinces that allow these charges.

CHAPTER 1

CANADA HEALTH ACT OVERVIEW

This section describes the *Canada Health Act*, its requirements, key definitions, regulations and regulatory provisions, letters by former federal Ministers of Health Jake Epp and Diane Marleau to their provincial and territorial counterparts that are used in the interpretation and application of the Act, and from former federal Minister, Anne McLellan, to her provincial and territorial counterparts on the Canada Health Act Dispute Avoidance and Resolution process. A history of the evolution of federal health care transfers follows.

WHAT IS THE CANADA HEALTH ACT?

The *Canada Health Act* is Canada's federal legislation for publicly funded health care insurance. The Act sets out the primary objective of Canadian health care policy, which is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."

The Act establishes criteria and conditions related to insured health services and extended health care services that the provinces and territories must fulfill to receive the full federal cash contribution under the Canada Health Transfer (CHT).

The aim of the Act is to ensure that all eligible residents of Canada have reasonable access to medically necessary services on a prepaid basis, without direct charges related to the provision of insured health services.

Key Definitions Under the Canada Health Act

Insured persons are eligible residents of a province or territory. A resident of a province is defined in the Act as "a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province."

Persons excluded under the Act include serving members of the Canadian Forces or Royal Canadian Mounted Police[1] and inmates of federal penitentiaries.

Insured health services are medically necessary hospital, physician and surgical-dental services (performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedure) provided to insured persons.

Insured hospital services are defined under the Act and include medically necessary in- and out-patient services such as accommodation and meals at the standard or public ward level and preferred accommodation if medically required; nursing service; laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; drugs, biologicals and related preparations when administered in the hospital; use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies; medical and surgical equipment and supplies; use of radiotherapy facilities; use of physiotherapy facilities; and services provided by persons who receive remuneration therefore from the hospital, but does not include services that are excluded by the regulations.

Insured physician services are defined under the Act as "medically required services rendered by medical practitioners." Medically required physician services are generally determined by physicians in conjunction with their provincial and territorial health insurance plans.

Insured surgical-dental services are services provided by a dentist in a hospital, where a hospital setting is required to properly perform the procedure.

Extended health care services, as defined in the Act, are certain aspects of long-term residential care (nursing home intermediate care and adult residential care services), and the health aspects of home care and ambulatory care services.

1. On June 29, 2012, the *Jobs, Growth and Long-term Prosperity Act* amended the *Canada Health Act* to remove members of the RCMP from the list of persons excluded from the definition of insured person under the *Canada Health Act*.

REQUIREMENTS OF THE CANADA HEALTH ACT

The *Canada Health Act* contains nine requirements that the provinces and territories must fulfill in order to qualify for the full amount of their cash entitlement under the CHT. They are:

- five program criteria that apply only to insured health services;
- two conditions that apply to insured health services and extended health care services; and
- extra-billing and user charges provisions that apply only to insured health services.

The Criteria

1. Public Administration (section 8)

The public administration criterion, set out in section 8 of the *Canada Health Act*, applies to provincial and territorial health care insurance plans. The intent of the public administration criterion is that the provincial and territorial health care insurance plans be administered and operated on a non-profit basis by a public authority, which is accountable to the provincial or territorial government for decision-making on benefit levels and services, and whose records and accounts are publicly audited. However, the criterion does not prevent the public authority from contracting out the administrative services necessary for the administration of the provincial and territorial health care insurance plans.

The public administration criterion pertains only to the administration of provincial and territorial health insurance plans and does not preclude private facilities or providers from supplying insured health services as long as no eligible resident is charged in relation to these services.

2. Comprehensiveness (section 9)

The comprehensiveness criterion of the Act requires that the health care insurance plan of a province or territory must cover all insured health services provided by hospitals, physicians or dentists (i.e., surgical-dental services that require a hospital setting) and, where the law of the province so permits, similar or additional services rendered by other health care practitioners.

3. Universality (section 10)

Under the universality criterion, all insured residents of a province or territory must be entitled to the insured health services provided by the provincial or territorial health care insurance plan on uniform terms and conditions. Provinces and territories generally require that residents register with the plans to establish entitlement.

Newcomers to Canada, such as immigrants or Canadians returning from other countries to live in Canada, may be subject to a waiting period by a province or territory, not to exceed three months, before they are entitled to receive insured health services.

4. Portability (section 11)

Residents moving from one province or territory to another must continue to be covered for insured health services by the "home" jurisdiction during any waiting period imposed by the new province or territory of residence. The waiting period for eligibility to a provincial or territorial health care insurance plan must not exceed three months. After the waiting period, the new province or territory of residence assumes responsibility for health care coverage. However, it is the responsibility of residents to inform their province or territory's health care insurance plan that they are leaving and to register with the health care insurance plan of their new province or territory.

Residents who are temporarily absent from their home province or territory or from Canada, must continue to be covered for insured health services during their absence. This allows individuals to travel or be absent from their home province or territory, within a prescribed duration, while retaining their health insurance coverage.

The portability criterion does not entitle a person to seek services in another province, territory or country, but is intended to permit a person to receive necessary services in relation to an urgent or emergent need when absent on a temporary basis, such as on business or vacation.

If insured persons are temporarily absent in another province or territory, the portability criterion requires that insured services be paid at the host province's rate. If insured persons are temporarily out of the country, insured services are to be paid at the home province's rate.

Prior approval by the health care insurance plan in a person's home province or territory may be required before

coverage is extended for elective (non-emergency) services to a resident while temporarily absent from his or her province or territory.

5. Accessibility (section 12)

The intent of the accessibility criterion is to ensure that insured persons in a province or territory have reasonable access to insured hospital, medical and surgical-dental services on uniform terms and conditions, unprecluded or unimpeded, either directly or indirectly, by charges (user charges or extra-billing) or other means (e.g., discrimination on the basis of age, health status or financial circumstances).

In addition, health care insurance plans of the province or territory must provide:

- reasonable compensation to physicians and dentists for all the insured health services they provide; and
- payment to hospitals to cover the cost of insured health services.

Reasonable access in terms of physical availability of medically necessary services has been interpreted under the *Canada Health Act* using the "where and as available" rule. Thus, residents of a province or territory are entitled to have access on uniform terms and conditions to insured health services at the setting "where" the services are provided and "as" the services are available in that setting.

The Conditions

1. Information (section 13(a))

The provincial and territorial governments shall provide information to the federal Minister of Health as may be reasonably required, in relation to insured health services and extended health care services, for the purposes of the Act.

2. Recognition (section 13(b))

The provincial and territorial governments shall recognize the federal financial contributions toward both insured and extended health care services.

Extra-billing and User Charges

The provisions of the *Canada Health Act* pertaining to extra-billing and user charges for insured health services in a province or territory are outlined in sections 18 to 21. If it can be confirmed that either extra-billing or user charges exist in a province or territory, a mandatory deduction from the federal cash transfer to that province or territory is required under the Act. The amount of such a deduction for a fiscal year is determined by the federal Minister of Health based on information provided by the province or territory in accordance with the Extra-billing and User Charges Information Regulations (described below).

Extra-billing (section 18)

Under the Act, extra-billing is defined as the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist (i.e., a dentist providing insured surgical-dental services in a hospital setting) in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province or territory. For example, if a physician was to charge a patient any amount for an office visit that is insured by the provincial or territorial health insurance plan, the amount charged would constitute extra-billing. Extra-billing is seen as a barrier or impediment for people seeking medical care, and is therefore contrary to the accessibility criterion.

User Charges (section 19)

The Act defines user charges as any charge for an insured health service other than extra-billing that is permitted by a provincial or territorial health care insurance plan and is not payable by the plan. For example, if patients were charged a facility fee for receiving an insured service at a hospital or clinic, that fee would be considered a user charge. User charges are not permitted under the Act because, as is the case with extra-billing, they constitute a barrier or impediment to access.

OTHER ELEMENTS OF THE ACT

Regulations (section 22)

Section 22 of the *Canada Health Act* enables the federal government to make regulations for administering the Act in the following areas:

- defining the services included in the Act's definition of "extended health care services";
- prescribing which services to exclude from hospital services;
- prescribing the types of information that the federal Minister of Health may reasonably require, and the times at which, and the manner in which, that information may be provided; and
- prescribing how provinces and territories are required to recognize the CHT in their documents, advertising or promotional materials.

To date, the only regulations in force under the Act are the Extra-billing and User Charges Information Regulations. These regulations require the provinces and territories to provide estimates of extra-billing and user charges before the beginning of a fiscal year so that appropriate penalties can be levied. They must also provide financial statements showing the amounts actually charged so that reconciliations with any estimated charges can be made. (A copy of these regulations is provided in Annex A.)

Penalty Provisions of the Canada Health Act

Mandatory Penalty Provisions

Under the Act, provinces and territories that allow extra-billing and user charges are subject to mandatory dollar-for-dollar deductions from the federal transfer payments under the CHT. For example, this means that when it has been determined that a province or territory has allowed $500,000 in extra-billing by physicians, the federal cash contribution to that province or territory will be reduced by that same amount.

Discretionary Penalty Provisions

Non-compliance with one of the five criteria or two conditions of the Act is subject to a discretionary penalty. The amount of any deduction from federal transfer payments under the CHT is based on the gravity of the default.

The *Canada Health Act* sets out a consultation process that must be undertaken with the province or territory before discretionary penalties can be levied. To date, the discretionary penalty provisions of the Act have not been applied.

EXCLUDED SERVICES AND PERSONS

Although the *Canada Health Act* requires that insured health services be provided to insured persons in a manner that is consistent with the criteria and conditions set out in the Act, not all Canadian residents or health services fall under the scope of the Act. There are two categories of exclusions:

- services that fall outside the definition of insured health services; and
- certain services and groups of persons are excluded from the definitions of insured services and insured persons.

These exclusions are discussed in the following section.

Excluded Services

In addition to the medically necessary hospital and physician services covered by the *Canada Health Act*, provinces and territories also provide a range of other programs and services. These are provided at provincial and territorial discretion, on their own terms and conditions, and vary from one province or territory to another. Additional services that may be provided include pharmacare, ambulance services and optometric services.

The additional services provided by provinces and territories are often targeted to specific population groups (e.g., children, seniors or social assistance recipients), and may be partially or fully covered by provincial and territorial health insurance plans.

A number of services provided by hospitals and physicians are not considered medically necessary, and thus are not insured under provincial and territorial health insurance legislation. Uninsured hospital services for which patients may be charged include preferred hospital accommodation unless prescribed by a physician, private duty nursing services and the provision of telephones and televisions. Uninsured physician services for which patients may be charged include telephone advice; the provision of medical certificates required for work, school, insurance purposes and fitness clubs; testimony in court; and cosmetic services.

In addition, the definition of "insured health services" excludes services to persons provided under any other Act of Parliament (e.g., refugees) or under the workers' compensation legislation of a province or territory.

Excluded Persons

The *Canada Health Act* definition of "insured person" excludes members of the Canadian Forces, persons appointed to a position of rank within the Royal Canadian Mounted Police[2] and persons serving a term of imprisonment within a federal penitentiary. The Government of Canada provides coverage to these groups through separate federal programs.

As well, other categories of residents such as landed immigrants and Canadians returning from other countries to live in Canada may be subject to a waiting period by a province or territory. The Act stipulates that the waiting period cannot exceed three months.

The exclusion of these persons from insured health service coverage predates the adoption of the Act and is not intended to constitute differences in access to publicly insured health care.

2. On June 29, 2012, the *Jobs, Growth and Long-term Prosperity Act* amended the *Canada Health Act* to remove members of the RCMP from the list of persons excluded from the definition of insured person under the *Canada Health Act*.

There is a Frequently Asked Questions link on Health Canada's website to address common concerns that Canadians might have about Canada's publicly funded health insurance plans.

See: http://hc-sc.gc.ca/hcs-sss/medi-assur/faq-eng.php

POLICY INTERPRETATION LETTERS

There are two key policy statements that clarify the federal position on the *Canada Health Act*. These statements were made in the form of ministerial letters from former federal ministers of health to their provincial and territorial counterparts. Both letters are reproduced in Annex B of this report.

Epp Letter

In June 1985, approximately one year following the passage of the *Canada Health Act* in Parliament, then-federal Minister of Health and Welfare Jake Epp wrote to his provincial and territorial counterparts to set out and confirm the federal position on the interpretation and implementation of the Act.

Minister Epp's letter followed several months of consultation with his provincial and territorial counterparts. The letter sets forth statements of federal policy intent that clarify the Act's criteria, conditions and regulatory provisions. These clarifications have been used by the federal government in assessing and interpreting compliance with the Act. The Epp letter remains an important reference for interpreting the Act.

Marleau Letter — Federal Policy on Private Clinics

Between February 1994 and December 1994, a series of seven federal/provincial/territorial meetings dealing wholly, or in part, with private clinics took place. At issue was the growth of private clinics providing medically necessary services funded partially by the public system and partially by patients, and their impact on Canada's universal, publicly funded health care system.

At the September 1994 federal/provincial/territorial meeting of health ministers in Halifax, all ministers of health present, with the exception of Alberta's health minister, agreed to "take whatever steps are required to regulate the development of private clinics in Canada."

Diane Marleau, the federal Minister of Health at the time, wrote to all provincial and territorial ministers of health on January 6, 1995, to announce the new Federal Policy on Private Clinics. The Minister's letter provided the federal interpretation of the *Canada Health Act* as it relates to the issue of facility fees charged directly to patients receiving medically necessary services at private clinics. The letter stated that the definition of "hospital" contained in the Act includes any public facility that provides acute, rehabilitative or chronic care. Thus, when a provincial or territorial health insurance plan pays the physician fee for a medically necessary service delivered at a private clinic, it must also pay the facility fee or face a deduction from federal transfer payments.

DISPUTE AVOIDANCE AND RESOLUTION PROCESS

In April 2002, then-federal Minister of Health A. Anne McLellan outlined in a letter to her provincial and territorial counterparts a *Canada Health Act* Dispute Avoidance and Resolution process, which was agreed to by provinces and territories, except Quebec. The process meets federal and provincial or territorial interests of avoiding disputes related to the interpretation of the principles of the Act and, when this is not possible, resolving disputes in a fair, transparent and timely manner.

The process includes the dispute avoidance activities of government-to-government information exchange; discussions and clarification of issues as they arise; active participation of governments in ad hoc federal/provincial/territorial committees on Act-related issues; and *Canada Health Act* advance assessments, upon request.

Where dispute avoidance activities prove unsuccessful, dispute resolution activities may be initiated, beginning with government-to-government fact-finding and negotiations. If these are unsuccessful, either minister of health involved may refer the issues to a third-party panel to undertake fact-finding and provide advice and recommendations.

The federal Minister of Health has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister will take the panel's report into consideration.

A copy of Minister McLellan's letter is included in Annex C of this report.

EVOLUTION OF FEDERAL HEALTH CARE TRANSFERS

Grants to help establish programs

Federal support for provincial health care goes back to the late 1940s when the National Health Grants were created. These grants were considered to be essential building blocks of a national health care system. While the grants were mainly

used to build up the Canadian hospital infrastructure, they also supported initiatives in areas such as professional training, public health research, tuberculosis control and cancer treatment. By the mid-1960s, the grants available to the provinces totalled more than $60 million annually.

In the mid-1950s in response to public pressures, the federal government agreed to provide financial assistance to provinces to help them establish health insurance programs. In January 1956, the federal government placed concrete proposals before the provinces to inaugurate a phased health insurance program, with priority given to hospital insurance and diagnostic services. Discussions on these proposals led to adopting the *Hospital Insurance and Diagnostic Services Act* in 1957. The implementation of the Hospital Insurance and Diagnostic Services (HIDS) program started in July 1958, by which time Newfoundland, Saskatchewan, Alberta, British Columbia and Manitoba were operating hospital insurance plans. By 1961, all provinces and territories were participating in the program.

The second phase of the federal intervention supporting provincial and territorial health insurance programs resulted from the recommendations of the Royal Commission on Health Services (Hall Commission). In its final report, tabled in 1964, the Hall Commission recommended establishing a new program that would ensure that all Canadians have access to necessary medical care (physician services, outside a hospital setting).

The *Medical Care Act* was introduced in Parliament in early December 1966, and received Royal Assent on December 21, 1966. The implementation of the Medical Care program started on July 1, 1968. By 1972, all provinces and territories were participating in the program.

Originally, the federal government's method of contributing to provincial and territorial hospital insurance programs was based on the cost to provinces and territories of providing insured hospital services. Under the *Hospital Insurance and Diagnostic Services Act* (1957), the federal government reimbursed the provinces and territories for approximately 50 percent of the costs of hospital insurance. Under the *Medical Care Act* (1966), the federal contribution was set at 50 percent of the average national per capita costs of the insured services, multiplied by the number of insured persons in each province and territory. Funding protocols based on conditional grants continued until the move to block funding was made in fiscal year 1977–1978.

Established Programs Financing

On April 1, 1977, federal funding supporting insured health care services was replaced by a block fund transfer with only general requirements related to maintaining a minimum standard of health services through the passage of the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act*, 1977. Known also as the EPF Act, the new legislation provided federal contributions to the provinces and territories for insured hospital and medical care services (as well as for post-secondary education) that were no longer tied to provincial expenditures. Rather, federal contributions made in fiscal year 1975-1976 under the existing cost-sharing programs were designated as the base year for contributions, to be escalated by the rate of growth of nominal Gross National Product and increases to the population.

Under the EPF Act, and subsequent funding arrangements, the total amount of the provincial and territorial health entitlement was made up of relatively equal cash and tax transfers. The federal tax transfer involves the federal government ceding some of its "tax room" to the provincial and territorial governments, reducing its tax rate to allow provinces to raise their tax rates by an equivalent amount. With the Established Programs Financing (EPF) "health" tax transfer, the changes in federal and provincial tax rates offset one another, meaning there was no net impact on taxpayers. The total amount of the health care entitlement did not change.

The EPF Act also included a new transfer for the Extended Health Care Services Program. This group of health care services, defined as nursing home intermediate care, adult residential care, ambulatory health care and the health aspects of home care, were block funded on the basis of $20 per capita for fiscal year 1977–1978, and subject to the same escalator as insured health services. This portion of the EPF transfer was made on a virtually unconditional basis and, unlike the insured services transfer, was not subject to specified program delivery criteria.

Under the prevailing legislative framework, the Government of Canada was required to withhold all of the monthly health care transfer to a province or territory for each month the conditions were not met. It was not until the enactment of the *Canada Health Act* in 1984 that special deduction provisions came into force allowing for dollar-for-dollar deductions for extra-billing and user charges, and discretionary deductions when provincial and territorial plans failed to fully comply with other provisions set out in the Act. These criteria and conditions remain in force to the present day.

Canada Health and Social Transfer

In the 1995 Budget, the federal government announced a restructuring of the EPF Act, then to be called the *Federal-Provincial Fiscal Arrangements Act*, with provisions for a Canada Health and Social Transfer (CHST). The new omnibus or block transfer, beginning in fiscal year 1996–1997, merged the health and post-secondary education funding of the EPF Act with Canada Assistance Plan funding (the federal/provincial cost-sharing arrangement for social services). When the CHST came into effect on April 1, 1996, provinces and territories received CHST cash and tax transfer in lieu of entitlements under the Canada Assistance Plan (CAP) and EPF. The new CHST cash amount provided to provinces and territories was less than the combined values of EPF and CAP, reflecting the need for fiscal restraint at the time the CHST was introduced. The 1995 and 1996 Budget legislation provided for total CHST amounts (cash and tax transfers) for the following years, with an annual floor of $11 billion for the cash component to apply until 2002–2003.

The new block fund was provided to uphold the national criteria in the *Canada Health Act* (public administration, comprehensiveness, universality, portability and accessibility) and the provisions relating to extra-billing and user charges, as well as maintaining the CAP-related national standard that no period of minimum residency be required or allowed with respect to social assistance. Extended health care services continued as part of the Act, subject only to providing information and recognizing the federal transfer, as set out in section 13 of the Act. These requirements have remained unchanged since 1984.

The new legislation also transferred the cash payment authority from Health Canada to the Department of Finance. However, the federal Minister of Health continued to be responsible for recommending the amounts of any deductions or withholdings pursuant to the conditions and criteria of the Act to the Governor in Council:

- for determining the amounts of any deductions pursuant to the extra-billing and user charges provisions of the Act; and
- for communicating all of these amounts to the Department of Finance before the CHST payment dates.

From 1997 to 2000, there were several increases to the cash portion of the CHST, including increases to the cash floor. In 1998, the cash floor was increased to $12.5 billion. With the federal government's return to surpluses, Budget 1999 announced an additional $11.5 billion for health care. Of this amount, $8 billion was provided in CHST cash over the following four years. The remaining $3.5 billion was provided through a trust fund notionally allocated over three years to provide provinces and territories flexibility over when to draw down the funds. Budget 2000 then provided an additional $2.5 billion for health care through another trust fund to provinces and territories, notionally allocated over four years.

2000 and 2003 Health Accords: Increasing and Restructuring Federal Support for Health

In 2000 and 2003, First Ministers met to discuss health care, focusing on reform, reporting and funding requirements. In 2000, the federal government announced $23.4 billion in new spending over five years on health care renewal and early childhood development. This included an additional $21.1 billion dollars in increases to the CHST cash contributions, as well as an additional $1.8 billion for targeted programs (medical equipment and primary health care reform), and $500 million for Canada Health Infoway.

In 2003, the government committed $36.8 billion over five years to support priority areas of health reform (primary care, home care and catastrophic drugs). This was provided through $14 billion in increased CHST transfers and $16 billion for the Health Reform Transfer, as well as $1.5 billion for medical equipment. This was in addition to $5.3 billion in federal direct spending on health information technologies, Aboriginal health initiatives, patient safety and other health-related federal initiatives.

The federal government also agreed to restructure the CHST to enhance the transparency and accountability of federal support for health.

The Canada Health Transfer

The CHST was restructured into two new transfers, the Canada Health Transfer (CHT) and Canada Social Transfer (CST), effective April 1, 2004. The CHT supports the Government of Canada's ongoing commitment to maintain the national criteria and conditions of the Canada Health Act. The CST; a block fund that supports post-secondary education and social assistance and social services, continues to give provinces and territories the flexibility to allocate funds among these social programs according to their respective priorities.

The existing CHST-legislated amounts were apportioned between the new transfers, with the percentage of cash and tax points allocated to each transfer reflecting provincial and territorial spending patterns among the areas supported by the transfers: 62 percent for the CHT and 38 percent for the CST.

2004 10-year Plan to Strengthen Health Care

Federal transfers to the provinces and territories were further increased as a result of the 10-Year Plan to Strengthen Health Care. Signed by all first Ministers on September 16, 2004, this initiative committed the Government of Canada to an additional $41.3 billion in funding, over ten years until 2013–2014, to the provinces and territories for health. This included $35.3 billion in increases to the CHT, $5.5 billion in Wait Times Reduction funding, and $500 million in support of diagnostic and medical equipment.

Budget 2007

To restore fiscal balance in Canada, Budget 2007 put all major transfers on a long-term, principles-based track to 2013–2014. In order to provide comparable treatment for all Canadians, regardless of where they live the budget legislated equal per capita cash support for the CST, starting in 2007–2008, and the CHT, starting after the 10-Year Plan to Strengthen Health Care concludes in 2013–2014. In addition, Budget 2007 invested an additional $1 billion to help provinces and territories introduce wait time guarantees, including initiatives delivered through Canada Health Infoway.

Recent Transfer Changes

As announced by the Government of Canada in December 2011, and legislated in the *Jobs, Growth and Long-term Prosperity Act*, the CHT will continue to grow at an annual rate of 6 percent for an additional three years beyond 2013–2014 (i.e., until 2016–2017). Starting in 2017–2018, the CHT will grow in line with a three-year moving average of nominal gross domestic product growth, with funding guaranteed to increase by at least three percent per year. This will see health transfers reach historic levels of an estimated $40 billion by the end of the decade.

Following up on the 2007 legislation for a transition to an equal per capita cash allocation for the CHT in 2014–2015, the *Jobs, Growth and Long-term Prosperity Act* ensured a fiscally responsible transition by providing protection so that no province or territory will receive less than its 2013–2014 CHT cash allocation in subsequent years as a result of the move to equal per capita cash.

Additional information on federal/provincial/territorial funding arrangements is available upon request from the Department of Finance, or by visiting its website at:

http://www.fin.gc.ca/access/fedprov-eng.asp#Major

CHAPTER 2

ADMINISTRATION AND COMPLIANCE

ADMINISTRATION

In administering the *Canada Health Act*, the federal Minister of Health is assisted by Health Canada staff at headquarters and in the regions, and by the Department of Justice.

Health Canada works with the provinces and territories to ensure that the principles of the Act are respected and always strives to resolve issues through consultation, collaboration and cooperation.

The Canada Health Act Division

The Canada Health Act Division at Health Canada is responsible for administering the Act. Members of the Division located in Ottawa and their colleagues in regional Health Canada offices fulfil the following ongoing functions:

- monitoring and analysing provincial and territorial health insurance plans for compliance with the criteria, conditions and extra-billing and user charges provisions of the Act;
- disseminating information on the Act and on publicly funded health care insurance programs in Canada;
- responding to inquiries about the Act and health insurance issues received by telephone, mail and the Internet, from the public, members of Parliament, government departments, stakeholder organizations and the media;
- developing and maintaining formal and informal partnerships with health officials in provincial and territorial governments for information sharing;
- developing and producing the Canada Health Act Annual Report on the administration and operation of the Act;
- conducting issue analysis and policy research to provide policy advice;
- collaborating with provincial and territorial health department representatives through the Interprovincial Health Insurance Agreements Coordinating Committee (see below);
- working in partnership with the provinces and territories to investigate and resolve compliance issues and pursue activities that encourage compliance with the Act; and
- informing the federal Minister of Health of possible non-compliance and recommending appropriate action to resolve the issue.

Interprovincial Health Insurance Agreements Coordinating Committee

The Canada Health Act Division chairs the Interprovincial Health Insurance Agreements Coordinating Committee and provides a secretariat for the Committee (IHIACC). The Committee was formed in 1991 to address issues affecting the interprovincial billing of insured hospital and physician services as well as issues related to registration and eligibility for health insurance coverage. It oversees the application of interprovincial health insurance agreements in accordance with the Act.

The within-Canada portability provisions of the Act are implemented through a series of bilateral reciprocal billing agreements between provinces and territories for hospital and physician services. This generally means that a patient's health card will be accepted, in lieu of payment, when the patient receives insured hospital or physician services in another province or territory. The province or territory providing the service will then directly bill the patient's home province. All provinces and territories participate in reciprocal hospital agreements and all, with the exception of Quebec, participate in reciprocal medical agreements. The intent of these agreements is to ensure that Canadian residents do not face point-of-service charges for medically required hospital and physician services when they travel in Canada. However, these agreements are interprovincial/territorial and are not required by the Act.

COMPLIANCE

Health Canada's approach to resolving possible compliance issues emphasizes transparency, consultation and dialogue with provincial and territorial health ministry officials. In most instances, issues are successfully resolved through consultation and discussion based on a thorough examination of the facts. To date, most disputes and issues related to administering and interpreting the *Canada Health Act* have

been addressed and resolved without resorting to deductions. Deductions have only been applied when all options to resolve an issue have been exhausted.

The Canada Health Act Division and regional office staff monitor the operations of provincial and territorial health care insurance plans in order to provide advice to the Minister on possible non-compliance with the Act. Sources for this information include: provincial and territorial government officials and publications; media reports; and correspondence received from the public and other non-governmental organizations.

Staff in the Compliance and Interpretation Unit, Canada Health Act Division, assess issues of concern and complaints on a case-by-case basis. The assessment process involves compiling all facts and information related to the issue and taking appropriate action. Verifying the facts with provincial and territorial health officials may reveal issues that are not directly related to the Act, while others may pertain to the Act but are a result of misunderstanding or mis-communication, such as eligibility for health insurance coverage and portability of health services within and outside Canada, and are resolved quickly with provincial or territorial assistance.

In instances where a *Canada Health Act* issue has been identified and remains after initial enquiries, Division officials ask the jurisdiction in question to investigate the matter and report back. Division staff discuss the issue and its possible resolution with provincial/territorial officials. Only if the issue is not resolved to the satisfaction of the Division after following the aforementioned steps, is it brought to the attention of the federal Minister of Health.

COMPLIANCE ISSUES

For the most part, provincial and territorial health care insurance plans meet the criteria and conditions of the *Canada Health Act*. However, on the basis of reports to Health Canada by their respective provincial health ministries, deductions were taken from the March 2012 Canada Health Transfer (CHT) payments to British Columbia, in respect of extra-billing and patient charges at surgical clinics, in the amount of $33,219, and Newfoundland and Labrador, in respect of extra-billing and user charges for insured surgical-dental services in the amount of $45,329, levied during fiscal year 2009–2010. Additionally, a deduction of $13,350 was taken from Newfoundland and Labrador's September 2011 CHT payment as a result of a statement received from that province for estimated extra-billing and user charges during 2011–2012.

In 2011–2012, Health Canada officials raised a number of issues with some provincial health ministries, primarily concerning patient charges for medically necessary services in private clinics, and queue jumping.

In March 2011, media reports indicated that a private primary care clinic in Calgary that charges its clients an enrollment and annual membership fee was offering its members preferred access to physicians for insured services, including after-hours service. Health Canada subsequently contacted Alberta Health and Wellness to express concerns that receiving insured services might be conditional upon the payment of fees, which would pose concerns under the accessibility criterion of the Act. Alberta Health and Wellness conducted an investigation into the clinic and in 2012 assured Health Canada that membership in the clinic is not a requirement for access to insured services and that members do not receive expedited or preferential access to insured services. Alberta Health and Wellness has also indicated that the Ministry will be undertaking a formal compliance investigation in 2013 to ensure that clinics that are charging membership fees are operating in compliance with provincial and federal legislation.

In June 2011, at the request of members of the legislative assembly, the RCMP investigated media allegations that Alberta Health Services had arranged for expedited access to insured health services for VIPs. Health Canada contacted Alberta Health and Wellness officials to express concerns over these allegations. In responding to Health Canada, Alberta Health and Wellness officials noted that the RCMP concluded that there was not a sufficient case for a criminal investigation and stated that the Alberta government had invited any person with knowledge of such practices to come forward, but none had. On February 28, 2012, the Government of Alberta announced that a public inquiry into allegations of queue jumping would be conducted in accordance with the *Health Quality Council of Alberta Act*, and appointed a commissioner to lead the inquiry in March 2012. Health Canada continues to monitor this situation.

In August 2011, Health Canada learned of a Toronto clinic that advertised 24-hour access to physicians and assistance with emergency room visits in exchange for an annual fee, and an Ottawa clinic that charged an annual fee for access to family physicians, as well as expedited specialist appointments, imaging and surgery. In both cases, Health Canada officials contacted officials at the Ontario Ministry of Health and Long-Term Care (MOHLTC) to raise concerns that patients could be charged for insured services and that access to insured services might be expedited for those paying such fees. The MOHLTC advised that they would investigate and take decisive, corrective action pursuant to the requirements of Ontario's *Commitment to the Future of Medicare Act*, if necessary.

In August 2011, Health Canada learned about a Whitby, Ontario paediatrician who was charging an annual membership fee in exchange for after-hours access to insured services and was refusing to take on patients who were not willing to pay the fee. That same month, the College of Physicians and

Surgeons of Ontario (CPSO) laid disciplinary charges against the physician. In June 2012, the Discipline Committee of the CPSO found that the membership fee failed to comply with the College's policy on Block Fees and Uninsured Services. Health Canada is currently in consultation with the MOHLTC to confirm that any user charges will be refunded to patients.

In February 2012, the Régie de l'assurance maladie du Québec (RAMQ) concluded its investigation of a Montreal clinic that had charged patients for services which are supposed to be fully covered under the provincial health insurance plan. The Régie's report noted that patients were charged for package deals called "forfait santé" as well as for accessory fees not allowed by RAMQ. The report noted that patients may apply to RAMQ for reimbursement and that RAMQ will then collect the money from the clinic. Health Canada expressed concerns over these fees with Quebec officials in March 2012 and is satisfied that RAMQ has addressed this issue by directing the clinic to change its practices in this regard.

In February 2012, the media reported that the Quebec Health Minister had requested that the Quebec College of Physicians investigate reports that some surgeons were advising patients that they could pay to have their surgeries done more quickly in the private system. Health Canada contacted Quebec officials in February 2012 to express concerns over these practices and continues to monitor the situation.

In February 2012, British Columbia asked Health Canada about the applicability of the *Canada Health Act* to a facility proposed to be built on a First Nations reserve. The federal Minister of Health confirmed that since the Act applies to all insured persons, including members of First Nations living on and off reserve, that the province has the jurisdiction and the responsibility for ensuring that the facility operates in a manner consistent with the requirements of the *Canada Health Act*.

HISTORY OF DEDUCTIONS AND REFUNDS UNDER THE CANADA HEALTH ACT

The *Canada Health Act*, which came into force April 1, 1984, reaffirmed the national commitment to the original principles of the Canadian health care system, as embodied in the previous legislation, the *Medical Care Act* and the *Hospital Insurance and Diagnostic Services Act*. By putting into place mandatory dollar-for-dollar penalties for extra-billing and user charges, the federal government took steps to eliminate the proliferation of direct charges for hospital and physician services, judged to be restricting the access of many Canadians to health care services due to financial considerations.

During the period 1984 to 1987, subsection 20(5) of the Act provided for deductions in respect of these charges to be refunded to the province if the charges were eliminated before April 1, 1987. By March 31, 1987, it was determined that all provinces, which had extra-billing and user charges, had taken appropriate steps to eliminate them. Accordingly, by June 1987, a total of $244,732,000 in deductions were refunded to New Brunswick ($6,886,000), Quebec ($14,032,000), Ontario ($106,656,000), Manitoba ($1,270,000), Saskatchewan ($2,107,000), Alberta ($29,032,000) and British Columbia ($84,749,000).

Following the Act's initial three-year transition period, under which refunds to provinces and territories for deductions were possible, penalties under the Act did not reoccur until fiscal year 1994–1995. Please refer to the table at the end of this section for a summary of deductions and refunds that have been made to provincial or territorial transfer payments since 1994–1995.

As a result of a dispute between the British Columbia Medical Association and the British Columbia government over compensation, several doctors opted out of the provincial health insurance plan and began billing their patients directly. Some of these doctors billed their patients at a rate greater than the amount the patients could recover from the provincial health insurance plan. This higher amount constituted extra-billing under the Act. Including deduction adjustments for prior years, dating back to fiscal year 1992–1993, deductions began in May 1994 and continued until extra-billing by physicians was banned when changes to British Columbia's Medicare Protection Act came into effect in September 1995. In total, $2,025,000 was deducted from British Columbia's cash contribution for extra-billing that occurred in the province between 1992–1993 and 1995–1996. These deductions were non-refundable, as were all subsequent deductions.

In January 1995, then federal Minister of Health, Diane Marleau, expressed concerns to her provincial and territorial colleagues about the development of two-tiered health care and the emergence of private clinics charging facility fees for medically necessary services. As part of her communication with the provinces and territories, Minister Marleau announced that the provinces and territories would be given more than nine months to eliminate these user charges, but that any province that did not, would face financial penalties under the *Canada Health Act*. Accordingly, beginning in November 1995, deductions were applied to the cash contributions to Alberta, Manitoba, Nova Scotia and Newfoundland and Labrador for non-compliance with the Federal Policy on Private Clinics.

From November 1995 to June 1996, total deductions of $3,585,000 were made to Alberta's cash contribution in respect of facility fees charged at clinics providing surgical, ophthalmological and abortion services. On October 1, 1996,

Alberta prohibited private surgical clinics from charging patients a facility fee for medically necessary services for which the physician fee was billed to the provincial health insurance plan.

Similarly, due to facility fees allowed at an abortion clinic, a total of $280,430 was deducted from Newfoundland and Labrador's cash contribution before these fees were eliminated, effective January 1, 1998.

From November 1995 to December 1998, deductions from Manitoba's Canada Health and Social Transfer (CHST) cash contribution amounted to $2,055,000, ending with the confirmed elimination of user charges at surgical and ophthalmology clinics, effective January 1, 1999. However, during fiscal year 2001–2002, a monthly deduction (from October 2001 to March 2002 inclusive) in the amount of $50,033 was levied against Manitoba's CHST cash contribution on the basis of a financial statement provided by the province showing that actual amounts charged with respect to user charges for insured services in fiscal years 1997–1998 and 1998–1999 were greater than the deductions levied on the basis of estimates. This brought total deductions levied against Manitoba to $2,355,201.

With the closure of a private clinic in Halifax effective November 27, 2003, Nova Scotia was deemed to be in compliance with the Federal Policy on Private Clinics. Before it closed, total deductions of $372,135 were made to Nova Scotia's CHST cash contribution for its failure to cover facility charges to patients while paying the physician fee. A final deduction of $5,463 was taken from the March 2005 CHT payment to Nova Scotia as a reconciliation of deductions that had already been taken for 2002–2003. A one-time positive adjustment in the amount of $8,121 was made to Nova Scotia's March 2006 CHT payment to reconcile amounts actually charged in respect of extra-billing and user charges with the penalties that had already been levied based on provincial estimates reported for fiscal 2003–2004.

In January 2003, British Columbia provided a financial statement in accordance with the Canada Health Act Extra-billing and User Charges Information Regulations, indicating aggregate amounts actually charged with respect to extra-billing and user charges during fiscal year 2000–2001, totalling $4,610. Accordingly, a deduction of $4,610 was made to the March 2003 CHST cash contribution.

In 2004, British Columbia did not report to Health Canada the amounts of extra-billing and user charges actually charged during fiscal year 2001–2002, in accordance with the requirements of the Extra-billing and User Charges Information Regulations. As a result of reports that British Columbia was investigating cases of user charges, a $126,775 deduction was taken from British Columbia's March 2004 CHST payment, based on the amount Health Canada estimated to have been charged during fiscal year 2001–2002.

Since 2005, the following deductions have been taken from British Columbia's CHT payments[1] on the basis of charges reported by the province for extra-billing and user charges (the fiscal year to which the deductions pertain are indicated in parentheses): $72,464 in March 2005 (2002–2003); $29,019 in March 2006 (2003–2004); $114,850 in March 2007 (2004–2005); $42,113 in March 2008 (2005–2006); $66,195 in March 2009 (2006–2007); $73,925 in March 2010 (2007–2008), $75,136 in March 2011 (2008–2009) and $33,219 in March 2012 (2009–10).

A deduction of $1,100 was taken from the March 2005 CHT payment to Newfoundland and Labrador as a result of patient charges for a magnetic resonance imaging scan in a hospital which occurred during 2002–2003. The March 2007 CHT payment to Nova Scotia was reduced by $9,460 in respect of extra-billing during fiscal year 2004–2005.

As a result of charges reported by the province to Health Canada, a deduction of $3,577 was taken from the March 2011 CHT payment to Newfoundland and Labrador for extra-billing and user charges that occurred during fiscal year 2008–2009. Based on a statement received from the province estimating user charges and extra-billing that would occur in 2011–2012, a deduction of $13,350 was made from the September 2011 CHT payment to Newfoundland and Labrador. Finally, a $45,329 deduction was taken from the March 2012 CHT payment to Newfoundland and Labrador for charges that occurred during fiscal year 2009–2010, as a result of charges reported by the province to Health Canada.

Since the passage of the *Canada Health Act*, from April 1984 to March 2012, deductions totalling $9,326,230 have been applied against provincial cash contributions in respect of the extra-billing and user charges provisions of the Act. This amount excludes deductions totalling $244,732,000 that were made between 1984 and 1987 and subsequently refunded to the provinces when extra-billing and user charges were eliminated.

1. The CHT resulted from the division of the Canada Health and Social Transfer (CHST) into two transfers, the Canada Health Transfer (CHT) and the Canada Social Transfer (CST), which became effective April 1, 2004.

Deductions and refunds to CHST/CHT cash contributions in accordance with the Canada Health Act since 1994–1995 (in dollars)

PROVINCE/ TERRITORY	1994–1995	1995–1996	1996–1997	1997–1998	1998–1999	1999–2000	2000–2001	2001–2002	2002–2003	2003–2004
NL	0	46,000	96,000	128,000	53,000	(42,570)	0	0	0	0
PEI	0	0	0	0	0	0	0	0	0	0
NS	0	32,000	72,000	57,000	38,950	61,110	57,804	35,100	11,052	7,119
NB	0	0	0	0	0	0	0	0	0	0
QC	0	0	0	0	0	0	0	0	0	0
ON	0	0	0	0	0	0	0	0	0	0
MB	0	269,000	588,000	586,000	612,000	0	0	300,201	0	0
SK	0	0	0	0	0	0	0	0	0	0
AB	0	2,319,000	1,266,000	0	0	0	0	0	0	0
BC	1,982,000	43,000	0	0	0	0	0	0	4,610	126,775
YK	0	0	0	0	0	0	0	0	0	0
NWT	0	0	0	0	0	0	0	0	0	0
NU	0	0	0	0	0	0	0	0	0	0
Total	**1,982,000**	**2,709,000**	**2,022,000**	**771,000**	**703,950**	**18,540**	**57,804**	**335,301**	**15,662**	**133,894**

PROVINCE/ TERRITORY	2004–2005	2005–2006	2006–2007	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012	TOTAL
NL	1,100	0	0	0	0	0	3,577	58,679	**343,786**
PEI	0	0	0	0	0	0	0	0	**0**
NS	5,463	(8,121)	9,460	0	0	0	0	0	**378,937**
NB	0	0	0	0	0	0	0	0	**0**
QC	0	0	0	0	0	0	0	0	**0**
ON	0	0	0	0	0	0	0	0	**0**
MB	0	0	0	0	0	0	0	0	**2,355,201**
SK	0	0	0	0	0	0	0	0	**0**
AB	0	0	0	0	0	0	0	0	**3,585,000**
BC	72,464	29,019	114,850	42,113	66,195	73,925	75,136	33,219	**2,663,306**
YK	0	0	0	0	0	0	0	0	**0**
NWT	0	0	0	0	0	0	0	0	**0**
NU	0	0	0	0	0	0	0	0	**0**
Total	**79,027**	**20,898**	**124,310**	**42,113**	**66,195**	**73,925**	**78,713**	**91,898**	**9,326,230**

Note: Deductions taken in a given year are made from that year's CHST/CHT payments and are reported in the Canada Health Act Annual Report for that fiscal year. Deductions made in one fiscal year may include adjustments to previous fiscal years.

CHAPTER 3

PROVINCIAL AND TERRITORIAL HEALTH CARE INSURANCE PLANS IN 2011–2012

The following chapter presents the 13 provincial and territorial health insurance plans that make up the Canadian publicly funded health insurance system. The purpose of this chapter is to demonstrate clearly and consistently the extent to which provincial and territorial plans fulfilled the requirements of the *Canada Health Act* program criteria and conditions in 2011–2012.

Officials in the provincial, territorial and federal governments have collaborated to produce the detailed plan overviews contained in Chapter 3. The information that Health Canada requested from the provincial and territorial departments of health for the report consists of two components:

- a narrative description of the provincial or territorial health care system relating to the criteria and conditions of the Act, which can be found following this chapter; and
- statistical information related to insured health services.

While all provinces and territories have submitted detailed descriptive information on their health insurance plans, Quebec chose not to submit supplemental statistical information which is contained in the tables in this year's report. The narrative component is used to help with the monitoring and compliance of provincial and territorial health care plans with respect to the requirements of the Act, while statistics help to identify current and future trends in the Canadian health care system.

To help provinces and territories prepare their submissions to the annual report, Health Canada provided them with the document; Canada Health Act Annual Report 2011–2012: A Guide for Updating Submissions (User's Guide). This guide is designed to help provinces and territories meet the reporting requirements of Health Canada. Annual revisions to the guide are based on Health Canada's analysis of health plan descriptions from previous annual reports and its assessment of emerging issues relating to insured health services.

The process for the Canada Health Act Annual Report 2011–2012 was launched late spring 2012 with bilateral teleconferences with each jurisdiction. An updated User's Guide was also sent to the provinces and territories at that time.

INSURANCE PLAN DESCRIPTIONS

For the following chapter, provincial and territorial officials were asked to provide a narrative description of their health insurance plan. The descriptions follow the program criteria areas of the *Canada Health Act* in order to illustrate how the plans satisfy these criteria. This narrative format also allows each jurisdiction to indicate how it met the *Canada Health Act* requirement for the recognition of federal contributions that support insured and extended health care services.

Provincial and Territorial Health Care Insurance Plan Statistics

Over time, the section of the annual report containing the statistical information submitted from the provinces and territories has been simplified and streamlined based on feedback received from provincial and territorial officials, and based on reviews of data quality and availability. The supplemental statistical information tables can be found at the end of each provincial or territorial narrative, except for Quebec.

The purpose of the statistical tables is to place the administration and operation of the *Canada Health Act* in context and to provide a national perspective on trends in the delivery and funding of insured health services in Canada that are within the scope of the federal Act.

The statistical tables contain resource and cost data for insured hospital, physician and surgical-dental services, by province and territory for five consecutive years ending on March 31, 2012. All information was provided by provincial and territorial officials.

Although efforts are made to capture data on a consistent basis, differences exist in the reporting on health care programs and services between provincial and territorial governments. Therefore, comparisons between jurisdictions are not made. Provincial and territorial governments are responsible for the quality and completeness of the data they provide.

ORGANIZATION OF THE INFORMATION

Information in the tables is grouped according to the nine subcategories described below.

Registered Persons: Registered persons are the number of residents registered with the health care insurance plans of each province or territory.

Insured Hospital Services Within Own Province or Territory: Statistics in this sub-section relate to the provision of insured hospital services to residents in each province or territory, as well as to visitors from other regions of Canada.

Insured Hospital Services Provided to Residents in Another Province or Territory: This sub-section presents out-of-province or out-of-territory insured hospital services that are paid for by a person's home jurisdiction when they travel to other parts of Canada.

Insured Hospital Services Provided Outside Canada: Hospital services provided out of country represent residents' hospital costs incurred while travelling outside of Canada that are paid for by their home province or territory.

Insured Physician Services Within Own Province or Territory: Statistics in this sub-section relate to the provision of insured physician services to residents in each province or territory, as well as to visitors from other regions of Canada.

Insured Physician Services Provided to Residents in Another Province or Territory: This sub-section reports on physician services that are paid by a jurisdiction to other provinces or territories for their visiting residents.

Insured Physician Services Provided Outside Canada: Physician services provided out of country represent residents' medical costs incurred while travelling outside of Canada that are paid by their home province or territory.

Insured Surgical-Dental Services Within Own Province or Territory: The information in this subsection describes insured surgical-dental services provided in each province or territory.

NEWFOUNDLAND AND LABRADOR

INTRODUCTION

The majority of publicly funded health services in Newfoundland and Labrador are delivered through four regional health authorities (RHA). They focus on the full continuum of care, including health promotion and protection, public health, community services, and acute and long-term care services.

In Newfoundland and Labrador, approximately 20,000 health care providers and administrators provide health services to over 500,000 residents.

Budget 2011–2012, "People and Prosperity – Responsible Investments for a Secure Future," included nearly $3 billion to improve health care for all residents. Budget 2012 investments demonstrate a continued commitment to health care throughout Newfoundland and Labrador while balancing responsibility to ensure the ongoing sustainability of the health care system. Budget 2012 investments focus on priority areas of dialysis, addressing drug costs, enhancing breast cancer screening, increasing access and improving infrastructure.

1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

Health care insurance plans managed by the Department of Health and Community Services include the Hospital Insurance Plan and the Medical Care Plan (MCP). Both plans are non-profit and publicly administered.

The *Hospital Insurance Agreement Act* is the legislation that enables the Hospital Insurance Plan. The Act gives the Minister of Health and Community Services the authority to make regulations for providing insured services on uniform terms and conditions to residents of the province under the conditions specified in the *Canada Health Act* and its regulations.

The *Medical Care Insurance Act*, 1999 empowers the Minister to administer a plan of medical care insurance for residents of the province. It provides for the development of regulations to ensure that the provisions of the statute meet the requirements of the *Canada Health Act* as it relates to administering the MCP.

The MCP facilitates the delivery of comprehensive medical care to all residents of the province by implementing policies, procedures and systems that permit appropriate compensation to providers for rendering insured professional services. The MCP operates in accordance with the provisions of the *Medical Care Insurance Act*, 1999 and regulations, and in compliance with the *Canada Health Act*.

There were no legislative amendments to the *Medical Care Insurance Act*, 1999 or the *Hospital Insurance Agreement Act* in 2011–2012.

1.2 Reporting Relationship

The Department is mandated with administering the Hospital Insurance and Medical Care Plans. The Department reports on these plans through the regular legislative processes, e.g., Public Accounts and the Estimates Committee of the House of Assembly.

The Government of Newfoundland and Labrador has a provincial planning and reporting requirement for all government departments, including the Department of Health and Community Services. Under the *Transparency and Accountability Act* (2006), the Department of Health and Community Services and the eight entities that report to the Minister, including RHAs, produce a strategic plan once every three years and report annually on performance. Plans and reports are tabled in the House of Assembly and posted on the Department's website. (www.gov.nl.ca/health/publications)

The 2011–2012 HCS Annual Report was tabled September 28, 2012.

1.3 Audit of Accounts

Each year, the province's Auditor General independently examines provincial public accounts. MCP expenditures are considered a part of the public accounts. The Auditor General has full and unrestricted access to MCP records.

The four RHAs are subject to financial statement audits, reviews, and compliance audits. Financial statement audits are performed by independent auditing firms that are selected by the health authorities under the terms of the *Public Tender Act*. Review engagements, compliance audits and physician audits were carried out by personnel from the Department under the authority of the *Medical Care Insurance Act*, 1999. Physician records and professional medical corporation records were reviewed to ensure that the records supported the services billed and that the services are insured under the MCP.

Beneficiary audits were performed by personnel from the Department under the *Medical Care Insurance Act, 1999*. Individual providers are randomly selected on a bi-weekly basis for audit.

2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

The *Hospital Insurance Agreement Act* and the Hospital Insurance Regulations, made thereunder, provide for insured hospital services in Newfoundland and Labrador.

Insured hospital services are provided for in- and out-patients in 15 hospitals, 22 community health centres and 14 community clinics. Insured services include: accommodations and meals at the standard ward level; nursing services; laboratory, radiology and other diagnostic procedures; drugs, biological and related preparations; medical and surgical supplies, operating room, case room and anaesthetic facilities; rehabilitative services (e.g., physiotherapy, occupational therapy, speech language pathology and audiology); out-patient and emergency visits; and day surgery.

The coverage policy for insured hospital services is linked to the coverage policy for insured medical services. The Department of Health and Community Services manages the process of adding or de-listing a hospital service from the list of insured services based on direction from the Lieutenant-Governor in Council. There were no services added or de-listed in 2011–2012.

2.2 Insured Physician Services

The enabling legislation for insured physician services is the *Medical Care Insurance Act, 1999* and the regulations made thereunder, which include:

- the Medical Care Insurance Insured Services Regulations;
- the Medical Care Insurance Beneficiaries and Inquiries Regulations; and
- the Physicians and Fee Regulations.

In 2011–2012, there were 1,115 physicians registered in the province.

For purposes of the Act, the following services are covered:

- all services properly and adequately provided by physicians to beneficiaries suffering from an illness requiring medical treatment or advice;
- group immunizations or inoculations carried out by physicians at the request of the appropriate authority; and
- diagnostic and therapeutic x-ray and laboratory services in facilities approved by the appropriate authority that are not provided under the *Hospital Insurance Agreement Act* and regulations made under the Act.

Physicians can choose not to participate in the health care insurance plan as outlined in section 12(1) of the *Medical Care Insurance Act, 1999*, namely:

12 (1) Where a physician providing insured services is not a participating physician, and the physician provides an insured service to a beneficiary, the physician is not subject to this Act or the regulations relating to the provision of insured services to beneficiaries or the payment to be made for the services except that he or she shall:

(a) before providing the insured service, if he or she wishes to reserve the right to charge the beneficiary for the service an amount in excess of that payable by the Minister under this Act, inform the beneficiary that he or she is not a participating physician and that the physician may so charge the beneficiary; and

(b) provide the beneficiary to whom the physician has provided the insured service with the information required by the Minister to enable payment to be made under this Act to the beneficiary in respect of the insured service.

(2) Where a physician who is not a participating physician provides insured services through a professional medical corporation, the professional medical corporation is not, in relation to those services, subject to this Act or the regulations relating to the provision of insured services to beneficiaries or the payment to be made for the services and the professional medical corporation and the physician providing the insured services shall comply with subsection (1).

As of March 31, 2012, there were no physicians who had opted out of the Medical Care Plan (MCP).

Lieutenant-Governor in Council approval is required to add to or to de-insure a physician service from the list of insured services. This process is managed by the Department in consultation with various stakeholders, including the provincial medical association and the public. There were no services

added or deleted during the 2011–2012 fiscal year to the list of insured physician services.

2.3 Insured Surgical-Dental Services

The provincial Surgical-Dental Program is a component of the MCP. Surgical-dental treatments provided to a beneficiary and carried out in a hospital by a licensed oral surgeon or dentist are covered by MCP if the treatment is specified in the Surgical-Dental Services Schedule.

Dentists may opt out of the MCP. These dentists must advise the patient of their opted-out status, stating the fees expected, and provide the patient with a written record of services and fees charged. As of March 31, 2012, there were no opted-out dentists.

Because the Surgical-Dental Program is a component of the MCP, management of the program is linked to the MCP process regarding changes to the list of insured services.

Addition of a surgical-dental service to the list of insured services must be approved by the Minister.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Hospital services not covered by MCP include: preferred accommodation at the patient's request; cosmetic surgery and other services deemed to be medically unnecessary; ambulance or other patient transportation before admission or upon discharge; private duty nursing arranged by the patient; non-medically required x-rays or other services for employment or insurance purposes; drugs (except anti-rejection and AZT drugs) and appliances issued for use after discharge from hospital; bedside telephones, radios or television sets for personal, non-teaching use; fibreglass splints; services covered by the Workplace Health, Safety and Compensation Commission or by other federal or provincial legislation; and services relating to therapeutic abortions performed in non-accredited facilities or facilities not approved by the College of Physicians and Surgeons of Newfoundland and Labrador.

The use of the hospital setting for any services deemed not insured by the MCP are also uninsured under the Hospital Insurance Plan. For purposes of the *Medical Care Insurance Act, 1999*, the following is a list of non-insured physician services:

- any advice given by a physician to a beneficiary by telephone;
- the dispensing by a physician of medicines, drugs or medical appliances and the giving or writing of medical prescriptions;
- the preparation by a physician of records, reports or certificates for, or on behalf of, or any communication to, or relating to, a beneficiary;
- any services rendered by a physician to the spouse and children of the physician;
- any service to which a beneficiary is entitled under an Act of the Parliament of Canada, an Act of the Province of Newfoundland and Labrador, an Act of the legislature of any province of Canada, or any law of a country or part of a country;
- the time taken or expenses incurred in travelling to consult a beneficiary;
- ambulance service and other forms of patient transportation;
- acupuncture and all procedures and services related to acupuncture, excluding an initial assessment specifically related to diagnosing the illness proposed to be treated by acupuncture;
- examinations not necessitated by illness or at the request of a third party except as specified by the Department;
- plastic or other surgery for purely cosmetic purposes, unless medically indicated;
- testimony in a court;
- visits to optometrists, general practitioners and ophthalmologists solely for determining whether new or replacement glasses or contact lenses are required;
- the fees of a dentist, oral surgeon or general practitioner for routine dental extractions performed in hospital;
- fluoride dental treatment for children under four years of age;
- excision of xanthelasma;
- circumcision of newborns;
- hypnotherapy;
- medical examination for drivers;
- alcohol/drug treatment outside Canada;
- consultation required by hospital regulation;
- therapeutic abortions performed in the province at a facility not approved by the College of Physicians and Surgeons of Newfoundland and Labrador;
- sex reassignment surgery, when not recommended by the Clarke Institute of Psychiatry;
- in vitro fertilization and OSST (ovarian stimulation and sperm transfer);

- reversal of previous sterilization procedure;
- surgical, diagnostic or therapeutic procedures provided in facilities as of January 1998 other than those listed in the Schedule to the *Hospitals Act* or approved by the appropriate authority under paragraph 3(d) of the Act; and
- other services not within the ambit of section 3 of the Act.

The majority of diagnostic services (e.g., laboratory services and x-ray) are performed within public facilities in the province. Hospital policy concerning access ensures that third parties are not given priority access.

Medical goods and services that are implanted and associated with an insured service are provided free of charge to the patient and are consistent with national standards of practice. Patients retain the right to financially upgrade standard medical goods or services. Standards for medical goods are developed by the hospitals providing those services in consultation with service providers.

The *Medical Care Insurance Act, 1999* provides the Lieutenant-Governor in Council with the authority to make regulations prescribing which services are or are not insured services for the purpose of the Act.

3.0 UNIVERSALITY

3.1 Eligibility

There were 527,714 people registered with the program as of March 31, 2012. Residents of Newfoundland and Labrador are eligible for coverage under the *Medical Care Insurance Act, 1999* and the *Hospital Insurance Agreement Act*. The *Medical Care Insurance Act, 1999* defines a "resident" as a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in the province, but does not include tourists, transients or visitors to the province.

The Medical Care Insurance Beneficiaries and Inquiries Regulations identify those residents eligible to receive coverage under the plans. MCP has established rules to ensure that the regulations are applied consistently and fairly in processing applications for coverage. MCP applies the standard that persons moving to Newfoundland and Labrador from another province become eligible on the first day of the third month following the month of their arrival.

Persons not eligible for coverage under the plans include: students and their dependants already covered by another province or territory; dependants of residents if covered by another province or territory; certified refugees and refugee claimants and their dependants; foreign workers with employment authorizations and their dependants who do not meet the established criteria; tourists, transients, visitors and their dependants; Canadian Forces and Royal Canadian Mounted Police (RCMP) personnel; inmates of federal prisons; and armed forces personnel from other countries who are stationed in the province. If the status of these individuals changes, they must meet the criteria for eligibility as noted above in order to become eligible.

3.2 Other Categories of Individual

Foreign workers, international students, clergy and dependants of North Atlantic Treaty Organization (NATO) personnel are eligible for benefits. Holders of Minister's permits are also eligible, subject to MCP approval.

4.0 PORTABILITY

4.1 Minimum Waiting Period

Insured persons moving to Newfoundland and Labrador from other provinces or territories are entitled to coverage on the first day of the third month following the month of arrival.

Persons arriving from outside Canada to establish residence are entitled to coverage on the day of arrival. The same applies to discharged members of the Canadian Forces and the RCMP, and individuals released from federal penitentiaries. For coverage to be effective; however, registration is required under the MCP. Immediate coverage is provided to persons from outside Canada authorized to work in the province for one year or more.

4.2 Coverage During Temporary Absences in Canada

Newfoundland and Labrador is a party to the Interprovincial Agreement on Eligibility and Portability regarding matters pertaining to portability of insured services in Canada.

Sections 12 and 13 of the Hospital Insurance Regulations define portability of hospital coverage during absences both within and outside Canada. The eligibility policy for insured hospital services is linked to the eligibility policy for insured physician services.

Coverage is provided to residents during temporary absences within Canada. The Government of Newfoundland and Labrador has entered into formal agreements (i.e., the Hospital Reciprocal Billing Agreement) with other provinces and territories for the reciprocal billing of insured hospital services. In-patient costs are paid at standard rates approved by the host province or territory. In-patient, high-cost procedures

and out-patient services are payable based on national rates agreed to by provincial and territorial health plans through the Interprovincial Health Insurance Agreements Coordinating Committee.

Medical services incurred in all provinces (except Quebec) or territories, are paid through the Medical Reciprocal Billing Agreement at host province or territory rates. Claims for medical services received in Quebec are submitted by the patient to the MCP for payment at host province rates.

In order to qualify for out-of-province coverage, a beneficiary must comply with the legislation and MCP rules regarding residency in Newfoundland and Labrador. A resident must reside in the province at least four consecutive months in each 12-month period to qualify as a beneficiary. Generally, the rules regarding medical and hospital care coverage during absences include the following:

- Before leaving the province for extended periods, a resident must contact the MCP to obtain an out-of-province coverage certificate.
- Beneficiaries leaving for vacation purposes may receive an initial out-of-province coverage certificate of up to 12 months. Upon return, beneficiaries are required to reside in the province for a minimum four consecutive months. Thereafter, certificates will only be issued for up to eight months of coverage.
- Students leaving the province may receive a certificate, renewable each year, provided they submit proof of full-time enrolment in a recognized educational institution located outside the province.
- Persons leaving the province for employment purposes may receive a certificate for coverage up to 12 months. Verification of employment may be required.
- Persons must not establish residence in another province, territory or country while maintaining coverage under the Newfoundland MCP.
- For out-of-province trips of 30 days or less, an out-of-province coverage certificate is not required, but will be issued upon request.
- For out-of-province trips lasting more than 30 days, a certificate is required as proof of a resident's ability to pay for services while outside the province.

Failure to request out-of-province coverage or failure to abide by the residency rules may result in the resident having to pay for medical or hospital costs incurred outside the province.

Insured residents moving permanently to other parts of Canada are covered up to and including the last day of the second month following the month of departure.

4.3 Coverage During Temporary Absences Outside Canada

The province provides coverage to residents during temporary absences outside Canada. Out-of-country insured hospital in- and out-patient services are covered for emergencies, sudden illness, and elective procedures at established rates. Hospital services are considered under the Plan when the insured services are provided by a recognized facility (licensed or approved by the appropriate authority within the state or country in which the facility is located) outside Canada. The maximum amount payable by the government's hospitalization plan for out-of-country in-patient hospital care is $350 per day, if the insured services are provided by a community or regional hospital. Where insured services are provided by a tertiary care hospital (a highly specialized facility), the approved rate is $465 per day. The approved rate for out-patient services is $62 per visit and hæmodialysis is $330 per treatment. The approved rates are paid in Canadian funds.

Physician services are covered for emergencies or sudden illness, and are also insured for elective services not available in the province or within Canada. Emergency Physician services are paid at the same rate as would be paid in Newfoundland and Labrador for the same service. If the elective services are not available in Newfoundland and Labrador, they are usually paid at Ontario rates, or at rates that apply in the province where they are available.

Coverage is immediately discontinued when residents move permanently to other countries.

4.4 Prior Approval Requirement

Prior approval is not required for medically necessary insured services provided by accredited hospitals or licensed physicians in the other provinces and territories. However, physicians may seek advice on coverage from the MCP so that patients may be made aware of any financial implications.

Prior approval is mandatory in order to receive funding at host country rates if a resident of the province has to seek specialized hospital care outside the country because the insured service is not available in Canada. The referring physicians must contact the Department for prior approval. If prior approval is granted, the provincial health insurance plan will pay the costs of insured services necessary for the patient's care. Prior approval is not granted for out-of-country treatment or elective services if the service is available in the province or elsewhere within Canada. If the services are not available in Newfoundland and Labrador, they are usually paid at Ontario rates, or at rates that apply in the province where they are available.

5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

Access to insured health services in Newfoundland and Labrador is provided on uniform terms and conditions. There are no co-insurance charges for insured hospital services and there is no extra-billing by physicians in the province.

The Department of Health and Community Services works closely with educational institutions within the province to maintain an appropriate supply of health professionals. The province also works with external organizations for health professionals not trained in this province. Targeted recruitment incentives are in place to attract health professionals. Several programs have been established to provide targeted sign-on bonuses, bursaries, opportunities for upgrading, and other incentives for a wide variety of health occupations.

In 2011–2012, a record investment of $2.9 billion was allocated for health operations, which signifies an increase of more than 7.4 percent over the previous year's $2.7 billion. This included investments in health care infrastructure totaling $272.2 million; investments for new construction and redevelopment totaling $200.6 million, $21.6 million for repairs and renovations and $50.0 million to purchase new medical equipment.

In 2011–2012, the Department of Health and Community Services established an Access and Clinical Efficiency Division to provide provincial leadership and oversight on the issues of reducing wait times and improving efficiency for key services in the province's health care system, and to continue monitoring and publicly reporting wait times for the national benchmarks established in 2005.

Through the work of this division, two five-year (2012–2017) provincial wait time reduction strategies were announced in February 2012:

The first, A Strategy to Reduce Wait Times for Hip and Knee Joint Replacement in Newfoundland and Labrador will focus on: shortening the wait time and improving coordination of the initial orthopedic assessment (Wait 1) and the services required by patients before and after hip and knee joint replacement surgeries are performed; improving the efficiency of hospital services associated with providing hip and knee joint replacement surgeries; reducing the backlog of patients waiting for joint replacement surgery; improving the collection and use of wait time data for joint replacement surgeries; and reducing the number of patients who require joint replacement in the longer term.

The second, A Strategy to Reduce Emergency Department Wait Times in Newfoundland and Labrador will focus on: improving the efficiency of high volume emergency departments; improving access to community-based health services that will support effective utilization of emergency departments; implementing a province-wide standard for patient triage and wait times to receive initial medical attention; improving the collection, reporting and use of emergency department wait time data; and, improving communication with patients and the public regarding emergency department wait times.

Provincial wait time data for the period ending March 31, 2012, shows that on average 88 per cent of residents of Newfoundland and Labrador received access to the priority benchmark services within the recommended time frames during the fourth quarter of 2011–2012 (January 1 to March 31). Almost 100 per cent of patients requiring radiation treatment for cancer continue to receive access within the benchmark of 28 days. Benchmark results show that 100 per cent of cardiac bypass patients continue to receive surgery more quickly than the recommended targets. Over 80 per cent of patients underwent cataract procedures within 112 days. Wait time results for hip replacement surgeries remained above 80 per cent within 182 days, while knee replacement surgeries increased to almost 80 per cent within 182 days. Also, 90 per cent of residents underwent surgery to repair a fractured hip within the benchmark of 48 hours.

In keeping with the Department Health and Community Service's strategic plan, wait times for select cancer surgery and endoscopy services will start to be publicly reported on the website in 2012–2013.

5.2 Physician Compensation

The legislation governing payments to physicians and dentists for insured services is the *Medical Care Insurance Act*, 1999. The current methods of remuneration to compensate physicians for providing insured health services include fee-for-service, salary, contract, and sessional block funding.

Compensation agreements are negotiated between the provincial government and the Newfoundland and Labrador Medical Association (NLMA), on behalf of all physicians. Representatives from the RHAs play a role in this process. A new Memorandum of Agreement was reached with the NLMA in December 2010, which increases overall physician compensation by approximately 26 percent. The Agreement expires on September 30, 2013. Physicians are paid via fee-for-service, salary or alternate payment plan (APP) with an increasing interest in APPs as a method of remuneration.

5.3 Payments to Hospitals

The Department is responsible for funding RHAs for ongoing operations and capital acquisitions. Funding for insured services is provided to the RHAs as an annual global budget. Payments are made in accordance with the *Hospital Insurance Agreement Act* and the *Regional Health Authorities Act*. As part of their accountability to the government, the health authorities are required to meet the Department's annual reporting requirements, which include audited financial statements and other financial and statistical information. The global budgeting process devolves the budget allocation authority, responsibility, and accountability to all appointed boards in the discharge of their mandates.

Throughout the fiscal year, the RHAs forwarded additional funding requests to the Department for any changes in program areas or increased workload volume. These requests were reviewed and, when approved by the Department, funded at the end of each fiscal year. Any adjustments to the annual funding level, such as for additional approved positions or program changes, were funded based on the implementation date of such increases and the cash flow requirements.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

Funding provided by the federal government through the Canada Health Transfer (CHT) and the Canada Social Transfer (CST) has been recognized and reported by the Government of Newfoundland and Labrador in the annual provincial budget, through press releases, government websites and various other documents. For fiscal year 2011–2012, these documents include:

- the 2011–2012 Public Accounts;
- the Estimates 2011–2012; and
- the Budget Speech 2011.

The Public Accounts and Estimates, tabled by the Government in the House of Assembly, are publicly available and have been shared with Health Canada for information purposes.

REGISTERED PERSONS					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
1. Number as of March 31st (#).	506,530	514,470	523,433	523,508	527,714

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
Public Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
2. Number (#).	50	51	51	51	51
3. Payments for insured health services ($).	798,018,159	880,628,613	964,078,687	1,028,697,016	1,088,392,487
Private For-Profit Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
4. Number of private for-profit facilities providing insured health services (#).	1	1	1	1	1
5. Payments to private for-profit facilities for insured health services ($).	307,825	389,375	432,500	660,625	697,375

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
6. Total number of claims, in-patient (#).	1,910	1,732	1,595	1,632	1,648
7. Total payments, in-patient ($).	16,509,144	15,695,411	16,928,930	21,096,749	17,507,684
8. Total number of claims, out-patient (#).	34,159	29,758	25,770	23,156	23,482
9. Total payments, out-patient ($).	6,817,250	7,680,172	7,325,977	7,214,089	7,216,918
INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA					
10. Total number of claims, in-patient (#).	73	90	94	97	126
11. Total payments, in-patient ($).	496,719	368,959	123,890	318,203	224,822
12. Total number of claims, out-patient (#).	404	400	317	445	475
13. Total payments, out-patient ($).	651,841	204,973	272,567	209,257	91,089

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
14. Number of participating physicians (#).[1]	989	1,037	1,075	1,096	1,115
15. Number of opted-out physicians (#).	0	0	0	0	0
16. Number of non-participating physicians (#).	0	0	0	0	0
17. Total payments for services provided by physicians paid through all payment methods ($).	not available	not available	not available	not available	not available
18. Total payments for services provided by physicians paid through fee-for-service ($).	189,169,000	199,127,000	211,145,000	216,931,000	218,561,000

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
19. Number of services (#).	168,000	136,000	147,000	155,000	154,000
20. Total payments ($).	6,320,000	6,161,000	6,991,000	6,665,000	6,627,000
INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA					
21. Number of services (#).	2,300	2,900	3,100	3,600	3,400
22. Total payments ($).	300,000	240,000	157,000	202,000	237,000

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
23. Number of participating dentists (#).	25	25	31	29	25
24. Number of services provided (#).	885	2,995	290	1,093	2,222
25. Total payments ($).	73,000	331,000	28,000	158,000	329,000

1. Excludes inactive physicians.Total salaried and fee-for-service.

PRINCE EDWARD ISLAND

INTRODUCTION

In Prince Edward Island the Department of Health and Wellness is responsible for providing policy, strategic and fiscal leadership for the healthcare system.

The *Health Services Act* provides the regulatory and administrative frameworks for improvements to the healthcare system in Prince Edward Island by:

- mandating the creation of a provincial health plan;
- establishing mechanisms to improve patient safety and support quality improvement processes; and
- creating a Crown corporation ("Health PEI") to oversee the delivery of operational healthcare services.

Within this governance structure Health PEI is responsible to:

- provide, or provide for the delivery of, health services;
- operate and manage health facilities;
- manage the financial, human and other resources necessary to provide health services and operate health facilities; and
- perform such other duties as the Minister may direct.

1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

The Hospital Services Insurance Plan, under the authority of the Minister of Health and Wellness, is the vehicle for delivering hospital care insurance in Prince Edward Island. The enabling legislation is the *Hospital and Diagnostic Services Insurance Act* (1988). The Medical Services Insurance Plan provides for insured physician services under the authority of the *Health Services Payment Act* (1988). Together, the Plans insure services as defined under section 2 of the *Canada Health Act*.

The Department of Health and Wellness is responsible for providing policy, strategic and fiscal leadership for the healthcare system, while Health PEI is responsible for service delivery and the operation of hospitals, health centres, manors and mental health facilities. Health PEI is responsible for the hiring of physicians, while the Public Service Commission of PEI hires nurse practitioners, nurses and all other health related workers.

1.2 Reporting Relationship

An annual report is submitted by the Department to the Minister responsible who tables it in the Legislative Assembly. The report provides information about the operating principles of the Department and its legislative responsibilities, as well as an overview and description of the operations of the departmental divisions and statistical highlights for the year.

Health PEI prepares an annual business plan which functions as a formal agreement between Health PEI and the Minister responsible, and documents accomplishments to be achieved over the coming fiscal year.

1.3 Audit of Accounts

The provincial Auditor General conducts annual audits of the public accounts of the province of Prince Edward Island. The public accounts of the province include the financial activities, revenues and expenditures of the Department of Health and Wellness. Public Accounts Volume I *Consolidated Financial Statements* was published in August 2011. Public Accounts Volume II *Operating Fund Financial Statements, Details of Revenues and Expenditures, Financial Statements of Agencies and Crown Corporations* was published in November 2011.

The provincial Auditor General, through the *Audit Act*, has the discretionary authority to conduct further audit reviews on a comprehensive or program specific basis.

2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

Insured hospital services are provided under the *Hospital and Diagnostic Services Insurance Act* (1988). The accompanying Regulations (1996) define the insured in- and out-patient hospital services available at no charge to a person who is eligible. Insured hospital services include: necessary nursing services; laboratory, radiological and other diagnostic procedures; accommodations and meals at a standard ward

rate; formulary drugs, biologicals and related preparations prescribed by an attending physician and administered in hospital; operating room, case room and anaesthetic facilities; routine surgical supplies; and radiotherapy and physiotherapy services performed in hospital.

The process to add a new hospital service to the list of insured services involves extensive consultation and negotiation between the Department, Health PEI and key stakeholders. The process involves the development of a business plan which, when approved by the Minister, would be taken to Treasury Board for funding approval. Executive Council (Cabinet) has the final authority in adding new services.

2.2 Insured Physician Services

The enabling legislation that provides for insured physician services is the *Health Services Payment Act* (1988).

Insured physician services are provided by medical practitioners licensed by the College of Physicians and Surgeons. The total number of practicing practitioners who billed the Medical Services Insurance Plan as of March 31, 2012 was 232.

Under section 10 of the *Health Services Payment Act*, a physician or practitioner who is not a participant in the Medical Services Insurance Plan is not eligible to bill the Plan for services rendered. When a non-participating physician provides a medically required service, section 10(2) requires that physicians advise patients that they are not participating physicians or practitioners and provide the patient with sufficient information to enable recovery of the cost of services from the Minister of Health and Wellness. Under section 10.1 of the *Health Services Payment Act*, a participating physician or practitioner may determine, subject to and in accordance with the regulations and in respect of a particular patient or a particular basic health service, to collect fees outside the Plan or selectively opt out of the Plan. Before the service is rendered, patients must be informed that they will be billed directly for the service. Where practitioners have made that determination, they are required to inform the Minister thereof and the total charge is made to the patient for the service rendered.

As of March 31, 2012, no physicians had opted out of the Medical Services Insurance Plan.

Any basic health services rendered by physicians that are medically required are covered by the Medical Services Insurance Plan. These include most physicians' services in the office, at the hospital or in the patient's home; medically necessary surgical services, including the services of anaesthetists and surgical assistants where necessary; obstetrical services, including pre- and post-natal care, newborn care or any complications of pregnancy such as miscarriage or caesarean section; certain oral surgery procedures performed by an oral surgeon when it is medically required, with prior approval that they be performed in a hospital; sterilization procedures, both female and male; treatment of fractures and dislocations; and certain insured specialist services, when properly referred by an attending physician.

The process to add a physician service to the list of insured services involves negotiation between the Department, Health PEI and the Medical Society. The process involves development of a business plan which, when approved by the Minister, would be taken to Treasury Board for funding approval. Insured physician services may also be added or deleted as part of the negotiation of a new Master Agreement with physicians (Section 5.2). Cabinet has the final authority in adding new services.

2.3 Insured Surgical-Dental Services

Dental services are not insured under the Medical Services Insurance Plan. Only oral maxillofacial surgeons are paid through the Plan. There are currently two surgeons in that category. Surgical-dental procedures included as basic health services in the Tariff of Fees are covered only when the patient's medical condition requires that they be done in hospital or in an office with prior approval, as confirmed by the attending physician.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Provincial hospital services not covered by the Hospital Services Insurance Plan include:

- services that persons are eligible for under other provincial or federal legislation;
- mileage or travel, unless approved by Health PEI;
- telephone consultation except by internists, palliative care physicians, paediatricians, out of province specialists, and orthopaedic surgeons, provided the patient was not seen by that physician within 3 days of the telephone consult;
- examinations required in connection with employment, insurance, education, etc.;
- group examinations, immunizations or inoculations, unless prior approval is received from Health PEI;
- preparation of records, reports, certificates or communications, except a certificate of committal to a psychiatric, drug or alcoholism facility;

- testimony in court;
- travel clinic and expenses;
- surgery for cosmetic purposes unless medically required;
- dental services other than those procedures included as basic health services;
- dressings, drugs, vaccines, biologicals and related materials;
- eyeglasses and special appliances;
- chiropractic, podiatry, optometry, chiropody, osteopathy, naturopathy, and similar treatments;
- physiotherapy, psychology, and acupuncture except when provided in hospital;
- reversal of sterilization procedures;
- in vitro fertilization;
- services performed by another person when the supervising physician is not present or not available;
- services rendered by a physician to members of the physician's own household, unless approval is obtained from Health PEI; and
- any other services that the Department may, upon the recommendation of the negotiation process between the Department, Health PEI and the Medical Society, declare non-insured.

Provincial hospital services not covered by the Hospital Services Insurance Plan include private or special duty nursing at the patient's or family's request; preferred accommodation at the patient's request; hospital services rendered in connection with surgery purely for cosmetic reasons; personal conveniences, such as telephones and televisions; drugs, biologicals and prosthetic and orthotic appliances for use after discharge from hospital; and dental extractions, except in cases where the patient must be admitted to hospital for medical reasons with prior approval of Health PEI.

The process to de-insure services covered by the Medical Services Insurance Plan is done in collaboration with the Medical Society, Health PEI and the Department. No services were de-insured during the 2011-2012 fiscal year.

All Island residents have equal access to services. Third parties such as private insurers or the Workers' Compensation Board of Prince Edward Island do not receive priority access to services through additional payment.

Prince Edward Island has no formal process to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Department and Health PEI to monitor usage and service concerns.

3.0 UNIVERSALITY

3.1 Eligibility

The *Health Services Payment Act* and regulations, section 3, define eligibility for the Medical Services Insurance Plan. This Plan is designed to provide coverage for eligible Prince Edward Island residents. A resident is anyone legally entitled to remain in Canada and who makes his or her home and is ordinarily present on an annual basis for at least six months plus a day, in Prince Edward Island.

All new residents must register with the Department in order to become eligible. Persons who establish permanent residence in Prince Edward Island from elsewhere in Canada will become eligible for insured hospital and medical services on the first day of the third month following the month of arrival.

Residents who are ineligible for insured hospital and medical services coverage in Prince Edward Island are those who are eligible for certain services under other federal or provincial government programs, such as members of the Canadian Forces, inmates of federal penitentiaries, Workers' Compensation or Veterans Affairs Canada.

Ineligible residents may become eligible in certain circumstances. For example, members of the Canadian Forces become eligible on discharge or completion of rehabilitative leave. Penitentiary inmates become eligible upon release. In such cases, the province where the individual in question was stationed at the time of discharge or release, or release from rehabilitative leave, would provide initial coverage during the customary waiting period of up to three months. Parolees from penitentiaries will be treated in the same manner as discharged prisoners.

Foreign students, tourists, transients or visitors to Prince Edward Island do not qualify as residents of the province and are, therefore, not eligible for hospital and medical insurance benefits.

New or returning residents must apply for health coverage by completing a registration application from the Department. The application is reviewed to ensure that all necessary information is provided. A health card is issued and sent to the resident within two weeks. Renewal of coverage takes place every five years and residents are notified by mail six weeks before renewal.

The number of residents registered with the Medical Services Insurance Plan in Prince Edward Island as of March 31, 2012, was 147,942.

3.2 Other Categories of Individual

Foreign students, temporary workers, refugees and Minister's Permit holders are not eligible for hospital and medical insurance benefits.

4.0 PORTABILITY

4.1 Minimum Waiting Period

Insured persons who move to Prince Edward Island are eligible for health insurance on the first day of the third month following the month of arrival in the province.

4.2 Coverage During Temporary Absences in Canada

Persons absent each year for winter vacations and similar situations involving regular absences must reside in Prince Edward Island for at least six months plus a day each year in order to be eligible for sudden illness and emergency services while absent from the province, as allowed under section 5(1)(e) of the *Health Services Payment Act*.

The term "temporarily absent" is defined as a period of absence from the province for up to 182 days in a 12 month period, where the absence is for the purpose of a vacation, a visit or a business engagement. Persons leaving the province under the above circumstances must notify the Registration Department before leaving.

Prince Edward Island participates in the Hospital Reciprocal Billing Agreement and the Medical Reciprocal Billing Agreement along with other jurisdictions across Canada.

4.3 Coverage During Temporary Absences Outside Canada

The *Health Services Payment Act* is the enabling legislation that defines portability of health insurance during temporary absences outside Canada, as allowed under section 5(1)(e).

Insured residents may be temporarily out of the country for a 12 month period one time only. Students attending a recognized learning institution in another country must provide proof of enrolment from the educational institution on an annual basis. Students must notify the Registration Department upon returning from outside the country.

For Prince Edward Island residents leaving the country for work purposes for longer than one year, coverage ends the day the person leaves.

For Island residents travelling outside Canada, coverage for emergency or sudden illness will be provided at Prince Edward Island rates only, in Canadian currency. Residents are responsible for paying the difference between the full amount charged and the amount paid by the Department.

4.4 Prior Approval Requirement

Prior approval is required from Health PEI before receiving non-emergency, out-of-province medical or hospital services. Island residents seeking such required services may apply for prior approval through a Prince Edward Island physician. Full coverage may be provided for (Prince Edward Island insured) non-emergency or elective services, provided the physician completes an application to Health PEI. Prior approval is required from the Medical Director of Health PEI to receive out-of-country hospital or medical services not available in Canada.

5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

Both of Prince Edward Island's hospital and medical services insurance plans provide services on uniform terms and conditions on a basis that does not impede or preclude reasonable access to those services by insured persons.

Prince Edward Island has a publicly administered and funded health system that guarantees universal access to medically necessary hospital and physician services as required by the *Canada Health Act*.

Prince Edward Island recognizes that the health system must constantly adapt and expand to meet the needs of our citizens. Several examples of initiatives from the 2011–2012 fiscal year include:

- Following a successful two year pilot, Prince Edward Island announced the implementation of the Colorectal Cancer Screening Program this year. This program provides access to simple-to-use, home-based tests for all Islanders between ages 50 and 74.
- A major expansion of haemodialysis services in Prince Edward Island was undertaken this year. This will result in increased capacity of over 125 percent for haemodialysis services once these new facilities are completed.
- A major multi-year redevelopment project at our provincial referral hospital is well underway with construction nearing completion on the Ambulatory Care Centre at the Queen Elizabeth Hospital.

- This past year has also seen major investment as part of a long-term care manor replacement strategy. While two new manors held open houses, construction also began on another two new manors in different geographic regions of the province.
- The PEI Family Medicine Residency Program saw its first class graduate this year, with four individuals completing their two year residency. This is a major milestone for this program as the intent is to better integrate our medical students so that they will want to stay and practice in the province.

As PEI is primarily a rural province where a large segment of the population resides outside the main service centres, local access to health services, including acute services delivered through community hospitals and health centres, is important to small communities. Prince Edward Island continues to expand health infrastructure necessary to support health service delivery in rural communities.

5.2 Physician Compensation

A collective bargaining process is used to negotiate physician compensation. Bargaining teams are appointed by both physicians and the government to represent their interests in the process. The current five year Physician Master Agreement between the PEI Medical Society, on behalf of Island physicians, the Department of Health and Wellness, and Health PEI is effective April 1, 2010 to March 31, 2015.

The legislation governing payments to physicians and dentists for insured services is the *Health Services Payment Act*.

Many physicians continue to work on a fee-for-service basis. However, alternate payment plans have been developed and some physicians receive salary, contract and sessional payments. Alternate payment modalities are growing and seem to be the preference for new graduates. Currently, 67 percent of PEI's physicians (excluding locums and visiting specialists) are compensated under an alternate payment method (non-fee-for-service) as their primary means of remuneration.

5.3 Payments to Hospitals

Payments (advances) to provincial hospitals and community hospitals for hospital services are approved for disbursement by the Department in line with cash requirements and are subject to approved budget levels.

The usual funding method includes using a global budget adjusted annually to take into consideration increased costs related to such items as labour agreements, drugs, medical supplies and facility operations.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

The Government of Prince Edward Island strives to recognize the federal contributions provided through the Canada Health Transfer whenever appropriate. Over the past year, this has included reference in public documents such as the Province of PEI 2011–2012 Annual Budget and in the 2011–2012 Public Accounts, which both were tabled in the Legislative Assembly and are publicly available to Prince Edward Island residents.

It is also the intent of the Department of Health and Wellness to recognize this important contribution in its 2011–2012 Annual Report.

REGISTERED PERSONS					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
1. Number as of March 31st (#).	146,518	142,305	143,238	146,049	147,942

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
Public Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
2. Number (#).	7	7	7	7	7
3. Payments for insured health services ($).	137,982,600	151,304,500	161,439,600	172,100,500	183,647,900
Private For-Profit Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
4. Number of private for-profit facilities providing insured health services (#).	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services ($).	0	0	0	0	0

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
6. Total number of claims, in-patient (#).	2,253	2,591	2,692	2,564	2,509
7. Total payments, in-patient ($).	19,448,899	20,582,454	26,099,326	25,159,408	23,821,199
8. Total number of claims, out-patient (#).	17,867	18,488	17,147	16,763	15,391
9. Total payments, out-patient ($).	4,292,114	5,290,630	5,385,508	5,286,499	5,136,948
INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA					
10. Total number of claims, in-patient (#).	28	34	46	29	43
11. Total payments, in-patient ($).	49,616	113,901	157,547	70,768	164,610
12. Total number of claims, out-patient (#).	137	122	127	113	165
13. Total payments, out-patient ($).	27,533	33,919	65,114	44,213	58,796

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
14. Number of participating physicians (#).[1]	221	256	240	242	232
15. Number of opted-out physicians (#).	0	0	0	0	0
16. Number of non-participating physicians (#).	0	0	0	0	0
17. Total payments for services provided by physicians paid through all payment methods ($).	61,974,581 [2]	61,445,780 [2]	72,874,951 [2]	62,670,303 [2]	60,719,582 [2]
18. Total payments for services provided by physicians paid through fee-for-service ($).	34,973,359	41,123,808	45,959,450	49,332,788	50,264,859

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
19. Number of services (#).	77,992	77,830	79,139	80,559	83,086
20. Total payments ($).	6,035,626	5,998,751	6,386,325	6,247,907	6,330,440
INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA					
21. Number of services (#).	562	1,053	786	684	950
22. Total payments ($).	23,979	52,601	39,137	31,729	40,600

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
23. Number of participating dentists (#).	3	3	3	2	2
24. Number of services provided (#).	364	424	451	352	377
25. Total payments ($).	95,749	149,794	171,901	137,566	125,392

7. Total does not include locums or visiting specialists.
8. Reflects payments made through claim submissions and salary allocations.

NOVA SCOTIA

INTRODUCTION

The Nova Scotia Department of Health and Wellness mission is, "providing leadership to the health system for the delivery of care and treatment, prevention of illness and injury, and promotion of health and healthy living." This will further the collaborative effort to promote and protect health, prevent illness and injury, and reduce disparities in health status.

The *Health Authorities Act*, established the province's nine district health authorities (DHAs) and their community-based supports, community health boards (CHBs). DHAs are responsible for governing, planning, managing, delivering and monitoring health services within each district, and for providing planning support to the CHBs. Services delivered by the DHAs include acute and tertiary care, mental health, and addictions.

The province's thirty-seven CHBs develop community health plans with primary health care and health promotion as their foundation. DHAs draw two thirds of their board nominations from CHBs. Their community health plans are part of the DHAs' annual business planning process. In addition to the nine DHAs, the IWK Health Centre continues to have separate board, administrative and service delivery structures.

The Department of Health and Wellness is responsible for setting the strategic direction and standards for health services; ensuring availability of quality health care; monitoring, evaluating and reporting on performance and outcomes; and funding health services. The Department of Health and Wellness administers the following programs: physician and pharmaceutical services; emergency health; continuing care; and many other insured and publicly funded health programs and services.

Nova Scotia faces a number of challenges in the delivery of health care services. Nova Scotia's population is aging. Approximately 16.0% of the Nova Scotian population is sixty-five or over and this figure is expected to reach 24.3% by 2026. In response to the needs of the aging population, Nova Scotia has expanded its basket of publicly insured services to include home care, long term care, and enhanced pharmaceutical coverage. Nova Scotia also has much higher than average rates of chronic diseases such as cancers and diabetes which contribute to the rising costs of health care delivery.

Despite these ever increasing pressures and challenges, Nova Scotia continues to be committed to the delivery of medically necessary services consistent with the principles of the *Canada Health Act*.

Additional information related to health care in Nova Scotia may be obtained from the Department of Health and Wellness website at http://novascotia.ca/DHW.

1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

Two plans cover insured health services in Nova Scotia: the Hospital Services Insurance (HSI) and the Medical Services Insurance (MSI) Plans. The Department of Health and Wellness administers the HSI Plan, which operates under the *Health Services and Insurance Act*, Chapter 197, Revised Statutes of Nova Scotia, 1989: sections 3(1), 5, 6, 10, 15, 16, 17(1), 18 and 35.

The MSI Plan is administered and operated by an authority consisting of the Department of Health and Wellness and Medavie Blue Cross (formerly called Atlantic Blue Cross), under the above-mentioned Act (sections 8, 13, 17(2), 23, 27, 28, 29, 30, 31, 32 and 35).

Section 8 of the Act gives the Minister of Health and Wellness, with approval of the Governor in Council, the power to enter into agreements and vary, amend or terminate the same with such person or persons as the Minister deems necessary to establish, implement and carry out the MSI Plan.

The Department of Health and Wellness and Medavie Blue Cross entered into a service level agreement, effective August 1, 2005. Under the agreement, Medavie Blue Cross is responsible for operating and administering programs contained under MSI, Pharmacare Programs and Health Card Registration Services.

1.2 Reporting Relationship

In the service level agreement, Medavie Blue Cross is obliged to provide reports to the Department under various Statements of Requirements for each Business Service Description as listed in the contract. Medavie Blue Cross is audited every year on various areas of reporting.

Section 17(1)(i) of the *Health Services and Insurance Act*, and sections 11(1) and 12(1) of the Hospital Insurance Regulations, under this Act, set out the terms for reporting by hospitals and hospital boards to the Minister of Health and Wellness.

1.3 Audit of Accounts

The Auditor General audits all expenditures of the Department of Health and Wellness. Under its service level agreement with the Department of Health and Wellness, Medavie Blue Cross provides audited financial statements of Medical Services Insurance (MSI) costs to the Department of Health and Wellness. The Auditor General and the Department of Health and Wellness have the right to perform audits of the administration of the agreement with Medavie Blue Cross.

All long-term care facilities, home care and home support agencies are required to provide the Department of Health and Wellness with annual audited financial statements.

Under section 34(5) of the *Health Authorities Act*, every hospital board is required to submit to the Minister of Health and Wellness, by July 1st each year, an audited financial statement for the preceding fiscal year.

1.4 Designated Agency

Medavie Blue Cross Care administers and has the authority to receive monies to pay physician accounts under the service level agreement with the Department of Health and Wellness. Medavie Blue Cross Care receives written authorization from the Department of Health and Wellness for the physicians to whom it may makes payments. The rates of pay and specific amounts depend on the physician contract negotiated between Doctors Nova Scotia and the Department of Health and Wellness.

All MSI and Pharmacare transactions are subject to a review by the Office of the Auditor General.

Quikcard Solutions Incorporated (QSI) administers and has the authority to receive monies to pay dentists under a service level agreement with the Department of Health and Wellness. The tariff of dental fees is negotiated between the Nova Scotia Dental Association and the Department of Health and Wellness.

A report management schedule, developed between Medavie Blue Cross and the Department of Health and Wellness, outlines 95 required reports submitted to the Department at various points throughout the fiscal year. Reports pertain to medicare enrollment and monitoring, billing claims, provider management, audit and program utilization. These reports are submitted on a monthly, quarterly, or annual basis, and are intended to cover the previous reporting period. A complete list of reports can be obtained from the Nova Scotia Department of Health and Wellness.

As part of an agreement with the Department of Health and Wellness, Quikcard Solutions Incorporated also provides monthly, quarterly, and annual reports with regard to dental programs in Nova Scotia. This includes dental services provided in-hospital as outlined in the *Canada Health Act*. These reports address provider claims and payment, program utilization, and audit. A complete list of reports can be obtained from the Nova Scotia Department of Health and Wellness.

2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

Nine district health authorities and the IWK Health Centre — a women and children's tertiary care hospital — deliver insured hospital services to both in-patients and out-patients in Nova Scotia.

Accreditation is not mandatory, but all facilities are accredited at a facility or district level. The enabling legislation that provides for insured hospital services in Nova Scotia is the *Health Services and Insurance Act*, Chapter 197, Revised Statutes of Nova Scotia, 1989: sections 3(1), 5, 6, 10, 15, 16, 17(1), 18 and 35, passed by the Legislature in 1958. Hospital Insurance Regulations were made pursuant to the *Health Services and Insurance Act*.

In-patient services include:

- accommodation and meals at the standard ward level;
- necessary nursing services;
- laboratory, radiological and other diagnostic procedures;
- drugs, biologicals and related preparations, when administered in a hospital;
- routine surgical supplies;
- use of operating room(s), case room(s) and anaesthetic services;
- use of radiotherapy and physiotherapy services for in-patients, where available; and
- blood or therapeutic blood fractions.

Out-patient services include:

- laboratory and radiological examinations;
- diagnostic procedures involving the use of radio-pharmaceuticals;
- electroencephalographic examinations;
- use of occupational and physiotherapy facilities, where available;

- necessary nursing services;
- drugs, biologicals and related preparations;
- blood or therapeutic blood fractions;
- hospital services in connection with most minor medical and surgical procedures;
- day-patient diabetic care;
- services provided by the Nova Scotia Hearing and Speech Clinics, where available;
- ultrasonic diagnostic procedures;
- home parenteral nutrition, where available; and
- haemodialysis and peritoneal dialysis, where available.

In order to add a new hospital service to the list of insured hospital services, district health authorities are required to submit a New and/or Expanded Program Proposal[1] to the Department of Health and Wellness. This process is carried out annually by request through the business planning process. A Department-developed process format is forwarded to the districts for their guidance. A Department of Health and Wellness working group reviews and prioritizes all requests received. Based on available funding, a number of top priorities may be approved by the Minister of Health and Wellness.

2.2 Insured Physician Services

The legislation covering the provision of insured physician services in Nova Scotia is the *Health Services and Insurance Act*, sections 3(2), 5, 8, 13, 13A, 17(2), 22, 27-31, 35 and the Medical Services Insurance Regulations.

As of March 31, 2012, 2,473 physicians were paid through the Medical Services Insurance (MSI) Plan.

Physicians retain the ability to opt in or out of the MSI Plan. In order to opt out, a physician notifies MSI, relinquishing his or her billing number. MSI reimburses patients who pay the physician directly due to opting out. As of March 31, 2012, no physicians had opted out.

Insured services include those that are medically necessary. Medically necessary may be defined as services provided by a physician to a patient with the intent to diagnose or treat physical or mental disease or dysfunction, as well as those services generally accepted as promoting health through prevention of disease or dysfunction. Services that are not medically necessary are not insured. Services explicitly deemed as non-insured under the *Health Services and Insurance Act* or its Regulations remain uninsured regardless of individual judgments regarding the medical necessity.

Additional services were added to the list of insured physician services in 2011–2012. A complete list can be obtained from the Nova Scotia Department of Health and Wellness. On an as needed basis, new specific fee codes are approved that represent enhancements, new technologies or new ways of delivering a service.

The addition of new fee codes to the list of insured physician services is accomplished through a collaborative Department of Health and Wellness/District Health Authority/ Doctors Nova Scotia (DHW/DHA/DNS) committee structure. Physicians wishing to have a new fee code added to the MSI Manual submit a formal application to the Fee Schedule Advisory Committee (FSAC) for review. Each request is thoroughly researched. FSAC then makes a recommendation to the Master Agreement Steering Group (MASG) which either approves or denies the proposal. The MASG Committee is comprised of equal representation from Doctors Nova Scotia and the Department of Health and Wellness. If the fee is approved, Medavie Blue Cross is directed to add the new fee to the schedule of insured services payable by the MSI Plan.

2.3 Insured Surgical-Dental Services

To provide insured surgical-dental services under the *Health Services and Insurance Act*, dentists must be registered members of the Nova Scotia Dental Association and must also be certified competent in the practice of dental surgery. The *Health Services and Insurance Act* is so written that a dentist may choose not to participate in the MSI Plan. To participate, a dentist must register with MSI. A participating dentist who wishes to reverse election to participate must advise MSI in writing and is then no longer eligible to submit claims to MSI. In 2011–2012, 28 dentists were paid through the MSI Plan for providing insured surgical-dental services.

Insured surgical-dental services must be provided in a health care facility. Insured services are detailed in the Department of Health and Wellness MSI Dentist Manual (Dental Surgical Services Program) and are reviewed annually through the Acute & Tertiary Care Branch as required by Insured Dental Services Tariff Regulations. Services under this program are insured when the conditions of the patient are such that it is medically necessary for the procedure to be done in a hospital and the procedure is of a surgical nature. Generally included as insured surgical-dental services are orthognathic surgery, surgical removal of impacted teeth, and oral and maxillary facial surgery. Requests for an addition to the list of surgical-dental services are accomplished by first approaching the Dental Association of Nova Scotia and having them put forward a proposal to the Department of Health and Wellness for the addition of a new procedure. The Department of

1. Emergency/unexpected requirements may be considered at any time throughout the fiscal year.

Health and Wellness, in consultation with specific experts in the field, renders the decision as to whether or not the new procedure becomes an insured service.

"Other extraction services" (routine extractions) at public expense were approved for the following groups of patients: 1) cardiac patients, 2) transplant patients, 3) immunocompromised patients, and 4) radiation patients. Routine extractions for these patients will be provided at public expense only when patients are undergoing active treatment in a hospital setting and the attendant medical procedure must require the removal of teeth that would otherwise be considered routine extractions and not paid at public expense. It is vital to the claims approval process that the dental treatment plans include the name of the medical specialist providing the care and that he/she has indicated in writing in the patient's medical treatment plan that the routine dental extractions are required prior to performing the medical treatment/procedure.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include:

- preferred accommodation at the patient's request;
- telephones;
- televisions;
- drugs and biologicals ordered after discharge from hospital;
- cosmetic surgery;
- reversal of sterilization procedures;
- surgery for sex reassignment;
- in-vitro fertilization;
- procedures performed as part of clinical research trials;
- services such as gastric bypass for morbid obesity, breast reduction/augmentation and newborn circumcision;[2] and
- services not deemed medically necessary that are required by third parties, such as insurance companies.

Uninsured physician services include:

- services eligible for coverage under the *Workers' Compensation Act* or under any other federal or provincial legislation;
- mileage, travel or detention time;
- telephone advice or telephone renewal of prescriptions;
- examinations required by third parties;
- group immunizations or inoculations unless approved by the Department;
- preparation of certificates or reports;
- testimony in court;
- services in connection with an electrocardiogram, electromyogram or electroencephalogram, unless the physician is a specialist in the appropriate specialty;
- cosmetic surgery;
- acupuncture;
- reversal of sterilization; and
- in-vitro fertilization.

Major third party agencies currently purchasing medically necessary health services in Nova Scotia include Workers' Compensation, Department of National Defence, and the Royal Canadian Mounted Police.

All residents of the province are entitled to services covered under the *Health Services and Insurance Act*. If enhanced goods and services, such as foldable intraocular lens or fiberglass casts, are offered as an alternative, the specialist/physician is responsible to ensure that the patient is aware of their responsibility for the additional cost. Patients are not denied service based on their inability to pay. The province provides alternatives to any of the enhanced goods and services.

The Department of Health and Wellness also carefully reviews all patient complaints or public concerns that may indicate that the general principles of insured services are not being followed.

The de-insurance of insured physician services is accomplished through a negotiation process between Doctors Nova Scotia and the Physician Services Branch of the Department of Health and Wellness, who jointly evaluate a procedure or process to determine whether the services should remain an insured benefit. If a process or procedure is deemed not to be medically necessary, it is removed from the physician fee schedule and will no longer be reimbursed to physicians as an insured service. Once a service has been de-insured, all procedures and testing relating to the provision of that service also become de-insured. The same process applies to dental and hospital services. The last time there was any significant de-insurance of services was in 1997.

2. These services may be insured when approved as special consideration for medical reasons only.

3.0 UNIVERSALITY

3.1 Eligibility

Eligibility for insured health care services in Nova Scotia is outlined under section 2 of the Hospital Insurance Regulations made pursuant to section 17 of the *Health Services and Insurance Act*. All residents of Nova Scotia are eligible. A resident is defined as anyone who is legally entitled to stay in Canada and who makes his or her home and is ordinarily present in Nova Scotia.

A person is considered to be "ordinarily present" in Nova Scotia if the person:

- makes his or her permanent home in Nova Scotia;
- is physically present in Nova Scotia for at least 183 days in any calendar year (short term absences under 30 days, within Canada, are not monitored); and
- is a Canadian citizen or "Permanent Resident" as defined by Citizenship and Immigration Canada.

Persons moving to Nova Scotia from another Canadian province will normally be eligible for MSI on the first day of the third month following the month of their arrival. Persons moving permanently to Nova Scotia from another country are eligible on the date of their arrival in the province, provided they are Canadian citizens or hold "Permanent Resident" status as defined by Citizenship and Immigration Canada.

Individuals insured under the *Workers' Compensation Act* or any other Act of the Legislature or of the Parliament of Canada, or under any statute or law of any other jurisdiction either within or outside Canada, are not eligible for MSI coverage (such as members of the Canadian Forces, federal inmates and some classes of refugees). Once individuals are no longer covered under any of the Acts, statutes or laws noted above, they are then eligible to apply and receive Nova Scotia health insurance coverage, provided that they are either a Canadian citizen or a permanent resident as defined by Citizenship and Immigration Canada.

There were no changes to eligibility requirements in 2011–2012.

In 2011–2012, the total number of residents registered with the health insurance plan was 994,018.

3.2 Other Categories of Individuals

The following persons may also be eligible for insured health care services in Nova Scotia once they meet the specific eligibility criteria for their situations:

Immigrants: Persons moving from another country to live permanently in Nova Scotia are eligible for health care on the date of arrival. They must possess a landed immigrant document. These individuals, formerly called "landed immigrants," are now referred to as "Permanent Residents."

Convention Refugees and Non-Canadians married to Canadian Citizens/Permanent Residents (copy of Marriage Certificate required), who possess any other document and who have applied within Canada for Permanent Resident status, will be eligible on the date of application for Permanent Resident status, provided they possess a letter or documentation from Citizenship and Immigration Canada stating that they have applied for Permanent Residence.

Non-Canadians married to Canadian Citizens/Permanent Residents (copy of Marriage Certificate required), who possess any other document and who have applied outside Canada for Permanent Resident status, will be eligible on the date of arrival, provided they possess a letter or documentation from Citizenship and Immigration Canada stating that they have applied for Permanent Residence.

In 2011–2012, there were 32,610 Permanent Residents registered with the health care insurance plan.

Work Permits: Persons moving to Nova Scotia from outside the country who possess a work permit can apply for coverage on the date of arrival in Nova Scotia, providing they will be remaining in Nova Scotia for at least one full year. A declaration must be signed to confirm that the worker will not be outside Nova Scotia for more than 31 consecutive days, except in the course of employment. MSI coverage is extended for a maximum of 12 months at a time. Each year, a copy of their renewed immigration document must be presented and a declaration signed. Dependants of such persons, who are legally entitled to remain in Canada, are granted coverage on the same basis.

Once coverage has terminated, the person is to be treated as never having qualified for health services coverage as herein provided and must comply with the above requirements before coverage will be extended to him/her or their dependents.

In 2011–2012, there were 3,422 individuals with Employment Authorizations covered under the health care insurance plan.

Study Permits: Persons moving to Nova Scotia from another country and who possess a Study Permit will be eligible for MSI on the first day of the thirteenth month following the month of their arrival, provided they have not been absent from Nova Scotia for more than 31 consecutive days, except in the course of their studies. MSI coverage is extended for a maximum of 12 months at a time and only for services received within Nova Scotia. Each year, a copy of their renewed immigration document must be presented and a declaration signed. Dependants of such persons, who are legally entitled to remain in Canada, will be granted coverage on the same basis once the student has gained entitlement.

In 2011–2012, there were 1,362 individuals with Student Authorizations covered under the health care insurance plan.

Refugees: Refugees are eligible for MSI if they possess either a work permit or study permit.

4.0 PORTABILITY

4.1 Minimum Waiting Period

Persons moving to Nova Scotia from another Canadian province or territory will normally be eligible for Medical Services Insurance (MSI) on the first day of the third month following the month of their arrival.

4.2 Coverage During Temporary Absences in Canada

The Interprovincial Agreement on Eligibility and Portability is followed in all matters pertaining to the portability of insured services.

Generally, the Nova Scotia MSI Plan provides coverage for residents of Nova Scotia who move to other provinces or territories for a period of three months, per the Eligibility and Portability Agreement. Students and their dependants, who are temporarily absent from Nova Scotia and in full-time attendance at an educational institution, may remain eligible for MSI on a yearly basis. To qualify for MSI, the student must provide to MSI a letter directly from the educational institution which states that they are registered as full-time students. MSI coverage will be extended on a yearly basis pending receipt of this letter.

Workers who leave Nova Scotia to seek employment elsewhere will still be covered by MSI for up to 12 months, provided they do not establish residence in another province, territory or country. Services provided to Nova Scotia residents in other provinces or territories are covered by reciprocal agreements. Nova Scotia participates in the Hospital Reciprocal Billing Agreement and the Medical Reciprocal Billing Agreement.

Québec is the only province that does not participate in the medical reciprocal agreement. Nova Scotia pays for services provided by Québec physicians to Nova Scotia residents at Québec rates if the services are insured in Nova Scotia. The majority of such claims are received directly from Québec physicians. In-patient hospital services are paid through the interprovincial reciprocal billing arrangement at the standard ward rate of the hospital providing the service. The total amount paid by the plan in 2011–2012 for in-patient and out-patient hospital services received in other provinces and territories was $31,793,582.

Nova Scotia pays the host province rates for insured services in all reciprocal billing situations.

There were no changes made in Nova Scotia in 2011–2012 regarding in-Canada portability.

4.3 Coverage During Temporary Absences Outside Canada

Nova Scotia adheres to the Agreement on Eligibility and Portability for dealing with insured services for residents temporarily outside Canada. Provided a Nova Scotia resident meets eligibility requirements, out-of-country services will be paid, at a minimum, on the basis of the amount that would have been paid by Nova Scotia for similar services rendered in this province. Ordinarily, to be eligible for coverage, residents must not be outside the country for more than six months in a calendar year. In order to be covered, procedures of a non-emergency nature must have prior approval before they will be covered by MSI.

Students and their dependants who are temporarily absent from Nova Scotia and in full-time attendance at an educational institution outside Canada may remain eligible for MSI on a yearly basis. To qualify for MSI, the student must provide to MSI a letter obtained from the educational institution that verifies the student's attendance there in each year for which MSI coverage is requested.

Persons who engage in employment (including volunteer/missionary work/research) outside Canada which does not exceed 24 months are still covered by MSI, providing the person has already met the residency requirements.

Emergency out-of-country services are paid at a minimum on the basis of the amount that would have been paid by Nova Scotia for similar services rendered in this province. There were no changes made in Nova Scotia in 2011–2012 regarding out-of-Canada portability. The total amount spent in 2011–2012 for insured in-patient services provided outside of Canada was $2,176,921. Nova Scotia does not cover out-patient services out-of-country.

4.4 Prior Approval Requirement

Prior approval must be obtained for elective services outside the country. Application for prior approval is made to the Medical Director of the MSI Plan by a specialist in Nova Scotia on behalf of an insured resident. The medical consultant reviews the terms and conditions and determines whether or not the service is available in the province, or if it can be provided in another province or only out-of-country. The decision of the medical consultant is relayed to the patient's referring specialist. If approval is given to obtain service outside the country, the full cost of that service will be covered under MSI.

5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

Section 3 of the *Health Services and Insurance Act* states that subject to this Act and the regulations, all residents of the province are entitled to receive insured hospital services from hospitals on uniform terms and conditions. As well, all residents of the province are insured on uniform terms and conditions in respect of the payment of insured professional services to the extent of the established tariff. There are no user charges or extra charges allowed under the plan.

Nova Scotia continually reviews access situations across Canada to ensure equity of access. In areas where improvement is deemed necessary, depending on the province's financial situation, extra funding is generally allocated to that need.

In 2009, the province hired Dr. John Ross as the first provincial advisor on emergency care. His recommendations form the basis of the Better Care Sooner plan, released in 2010. The plan is designed to provide and enhance access to doctors, nurses and other healthcare professionals, streamlined patient-centred emergency care, better care for seniors, people with mental illness and other patients with complex needs, greater awareness of emergency telephone number (911) and the HealthLink 811 and funding for performance and quality of care. The plan has identified 32 action items to be implemented from 2011 to 2014.

As part of the plan, 5 new Collaborative Emergency Centers (CECs) have been opened to provide Nova Scotians living in smaller communities expanded access to primary health care, same day or next day access to appointments and 24/7 access to emergency care. The Department has worked with system partners to address several other areas of health care access. This has included opening a new Rapid Assessment Unit, the addition of 8 new hospital beds for Capital District Health Authority, and the establishment of stroke units across the province in regional hospitals.

Nova Scotia will also be expanding pre-habilitation orthopedic services to three more sites in the province, and expansion of full-field mammography at eleven fixed sites.

Access to Insured Physician and Surgical-Dental Services

Innovative funding solutions such as block funding and personal services contracts have enhanced recruitment.

Access to insured physician services has also been improved through the implementation of the CECs with improved access in evenings and on weekends.

The province has increased the capacity for medical education for both Canadian medical students and internationally educated physicians, coordinates ongoing recruitment activities, and has provided funding to create a re-entry program for general practitioners wishing to enter specialty training after completing two years of general practice service in the province.

5.2 Physician Compensation

The *Health Services and Insurance Act*, RS Chapter 197 governs payment to physicians and dentists for insured services. Physician payments are made in accordance with a negotiated agreement between Doctors Nova Scotia and the Nova Scotia Department of Health and Wellness. Doctors Nova Scotia is recognized as the sole bargaining agent in support of physicians in the province. When negotiations take place, representatives from Doctors Nova Scotia and the Department of Health and Wellness negotiate the total funding and other terms and conditions. The agreement lays out what the medical services unit value will be for physician services and addresses other issues such as the Canadian Medical Protective Association, membership benefits, emergency department payments, on-call funding, specific fee adjustments, dispute resolution processes, and other process or consultation issues.

Fee-for-service is still the most prevalent method of payment for physician services. However, there has been significant growth in the number of alternative payment arrangements in place in Nova Scotia. In the 1997–1998 fiscal year, about 9 percent of doctors were paid solely through alternative funding. In 2011–2012, approximately 23 percent of physicians were remunerated exclusively through alternative funding. Approximately 64 percent of physicians in Nova Scotia receive all or a portion of their remuneration through alternative funding mechanisms.

Alternative funding plans can be broken down into three groups:

1) Academic Funding Plan (these physicians are mainly located in Halifax at the Queen Elizabeth II Health Sciences Centre (QEII) and the IWK Health Centre (IWK)) — Most of the Academic Specialist groups are on academic funding arrangements with the exception of Urology, QEII and IWK Radiology, IWK Obstetrics & Gynaecology, Ophthalmology and Nephrology.
2) Currently there are regional specialist contracts for anaesthesiology, geriatrics, neonatology, paediatrics, obstetrics/gynaecology, and palliative care.
3) There are also contract arrangements available to general practitioners in certain rural areas and general practitioner/nurse practitioner contracts that support collaborative practice teams in designated areas.

Payment rates for dental services in the province are negotiated between the Department of Health and Wellness and the Nova Scotia Dental Association, and follow a process similar to physician negotiations. Dentists are paid on a fee-for-service basis. Negotiations are underway for renewal of these services.

5.3 Payments to Hospitals

The Department of Health and Wellness establishes budget targets for health care services. It does this by receiving business plans from the nine district health authorities (DHAs), the IWK Health Centre and other non-DHA organizations. Approved provincial estimates form the basis on which payments are made to these organizations for service delivery.

The *Health Authorities Act* was given Royal Assent on June 8, 2000. The Act instituted the nine DHAs and the IWK that replaced the former regional health boards.

The DHAs and the IWK are responsible (section 20 of the Act) for overseeing the delivery of health services in their districts, and are fully accountable for explaining their decisions on the community health plans through their business plan submissions to the Department of Health and Wellness.

Section 10 of the *Health Services and Insurance Act* and sections 9 through 13 of the Hospital Insurance Regulations define the terms for payments by the Minister of Health and Wellness to hospitals for insured hospital services.

In 2011–2012, there were 2928 hospital beds in Nova Scotia (3.1 beds per 1,000 population). Department of Health and Wellness direct expenditures for insured hospital services operating costs were increased to $1.59 billion.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

In Nova Scotia, the *Health Services and Insurance Act* acknowledges the federal contribution regarding the cost of insured hospital services and insured health services provided to provincial residents. The residents of Nova Scotia are aware of ongoing federal contributions to Nova Scotia health care through the Canada Health Transfer (CHT) as well as other federal funds through press releases and media coverage.

The Government of Nova Scotia also recognized the federal contribution under the CHT in various published documents, including the following documents:

- Public Accounts 2011–2012 released September 30, 2012; and
- Budget Estimates and Supplementary Detail 2011–2012 released April 3, 2012.

REGISTERED PERSONS					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
1. Number as of March 31st (#).	970,450	975,206	981,922	988,585	994,018

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
Public Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
2. Number (#).	35	35	35	35	35
3. Payments for insured health services ($).[3]	1,367,828,540	1,406,145,241	1,531,561,311 [4]	1,560,236,537	1,593,552,159
Private For-Profit Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
4. Number of private for-profit facilities providing insured health services (#).[5]	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services ($).	not available	not available	not applicable	not applicable	not applicable

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
6. Total number of claims, in-patient (#).	2,257	2,310	2,089	1,946	2,402
7. Total payments, in-patient ($).	16,726,553	15,924,363	16,289,798	13,614,172	19,417,809
8. Total number of claims, out-patient (#).	42,569	42,089	39,443	38,261	36,125
9. Total payments, out-patient ($).	8,946,688	11,558,634	11,180,204	10,978,035	12,375,773
INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA					
10. Total number of claims, in-patient (#).	not available	not available	not available	not available	not applicable
11. Total payments, in-patient ($).	1,257,620	1,190,016	1,286,181	788,368	2,176,921
12. Total number of claims, out-patient (#).	not available	not available	not available	not available	not applicable
13. Total payments, out-patient ($).	not available	not available	not available	not available	not applicable

3. This reflects payments made to the public facilities noted under indicator 2 above.
4. 2009–2010 includes payments to the DHAs for Care Coordination as program was integrated with the DHAs in the fiscal year.
5. Scotia Surgery is not considered private; it is classified as a hospital (funded by the Department of Health).

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
14. Number of participating physicians (#).	2,290	2,343	2,401	2,434	2,473
15. Number of opted-out physicians (#).	0	0	0	0	0
16. Number of non-participating physicians (#).	not applicable	not applicable	not applicable	not applicable	not applicable
17. Total payments for services provided by physicians paid through all payment methods ($).	555,659,788	598,546,450	637,434,810	661,968,168	681,963,292
18. Total payments for services provided by physicians paid through fee-for-service ($).	258,751,069	266,174,648	301,217,024	301,629,014	309,391,089

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
19. Number of services (#).	212,404	215,490	197,580	195,538	211,030
20. Total payments ($).	7,606,977	7,671,840	7,362,277	7,426,414	8,297,188
INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA					
21. Number of services (#).	2,701	3,051	3,418	3,092	3,295
22. Total payments ($).	134,729	161,555	200,452	169,312	185,142

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
23. Number of participating dentists (#).	27	29	55	26	28
24. Number of services provided (#).[6]	5,831	6,254	6,536	6,913	7,228
25. Total payments ($).[7]	1,215,333	1,374,645	1,380,344	1,459,608	1,338,592

6. Total services includes block funded dentists.
7. Total payments does not include block funded dentists.

NEW BRUNSWICK

INTRODUCTION

Through effective leadership and partnership, New Brunswick's health care system worked towards being more effective, adaptable and accountable within tight financial constraints, while continuing to provide excellent and trusted care to the public it served during 2011–2012.

New Brunswick remained committed to the five fundamental principles of the *Canada Health Act* (CHA), a commitment which was evident both in the day to day functioning of the various elements of New Brunswick's health system, and in new initiatives announced or implemented in 2011–2012.

For information about the Ministry's programs and services, please visit the New Brunswick Ministry of Health website at: http://www.gnb.ca/0051/index-e.asp.

1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

In New Brunswick, the formal name for "Medicare" is the Medical Services Plan. The Minister of Health ("Minister") is responsible for operating and administering the plan by virtue of the *Medical Services Payment Act* and its regulations. The Act and regulations set out who is eligible for Medicare coverage, the rights of the patient, and the responsibilities of the Department of Health ("the Department"). This law establishes a Medicare plan, and defines which Medicare services are covered and which are excluded. It also stipulates the type of agreements the Department may enter into with provinces and territories and with the New Brunswick Medical Society. As well, it specifies the rights of a medical practitioner; how the amounts to be paid for medical services will be determined; how assessment of accounts for medical services may be made; and confidentiality and privacy issues as they relate to the administration of the Act.

1.2 Reporting Relationship

The Medicare—Insured Services Branch and the Medicare—Eligibility and Claims Branch of the Department are mandated to administer the Medical Services Plan. The Minister reports to the Legislative Assembly through the Department's annual report and through regular legislative processes.

The *Regional Health Authorities Act* establishes the regional health authorities (RHAs) and sets forth the powers, duties and responsibilities of same. The Minister is responsible for the administration of the Act, provides direction to each RHA, and may delegate additional powers, duties or functions to the RHAs.

1.3 Audit of Accounts

Three groups have a mandate to audit the Medical Services Plan.

1) The Office of the Auditor General: In accordance with the *Auditor General Act*, the Office of the Auditor General conducts the external audit of the accounts of the Province of New Brunswick, which includes the financial records of the Department. The Auditor General also conducts management reviews on programs as he or she sees fit.
2) The Office of the Comptroller: The Comptroller is the chief internal auditor for the Province of New Brunswick and provides accounting, audit and consulting services in accordance with responsibilities and authority set out in the *Financial Administration Act*.
3) The Department's Internal Audit Unit was established to independently review and evaluate departmental activities as a service to all levels of management. Medicare also has a Monitoring and Compliance team, which is tasked with managing compliance to the *Medical Payment Services Act* and Regulations, as well as the Negotiated Fee Schedule.

2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

Legislation providing for insured hospital services includes the *Hospital Services Act*, section 9 of Regulation 84-167, and the *Hospital Act*. Under Regulation 84-167 of the *Hospital Services Act*, New Brunswick residents are entitled to the following insured in-patient and out-patient hospital services.

Insured in-patient services include: accommodation and meals; nursing; laboratory/diagnostic procedures; drugs; the use of facilities (e.g., surgical, radiotherapy, physiotherapy); and services provided by professionals within the facility.

Insured out-patient services include: laboratory and diagnostic procedures; mammography; and the hospital component of available out-patient services for maintaining health, preventing disease and helping diagnose/treat any injury, illness or disability, excluding those related to the provision of drugs or third party diagnostic requests.

2.2 Insured Physician Services

The *Medical Services Payment Act* and corresponding regulations provide for insured physician services. As of March 31, 2012 there were 1618 participating physicians in New Brunswick. No physicians rendering health care services have elected to opt out of the New Brunswick Medical Services Plan. When a physician opts out of Medicare, they must complete the specified Medicare claim form and indicate the amount charged to the patient. The beneficiary then seeks reimbursement by certifying on the claim form that the services have been received and forwarding the claim form to Medicare. The charges must not exceed the Medicare tariff. If the charges are in excess of the Medicare tariff, the practitioner must inform the beneficiary before rendering the service that:

- they have opted out and charge fees above the Medicare tariff;
- in accepting services under these conditions, the patient waives all rights to Medicare reimbursement;
- the patient is entitled to seek services from another practitioner who participates in the Medical Services Plan; and
- the physician must obtain a signed waiver from the patient on the specified form and forward the form to Medicare.

The services entitled under Medicare include:

a) the medical portion of all services rendered by medical practitioners that are medically required and;

b) certain surgical-dental procedures when performed by a physician or a dental surgeon in a hospital facility.

An individual, a physician or the Department may request the addition of a new service. All requests are considered by the New Service Items Committee, which is jointly managed by the New Brunswick Medical Society and the Department. The decision to add a new service is usually based on conformity to the definition of "medically necessary" and whether the service is considered generally acceptable practice (not experimental) within New Brunswick and Canada. Considerations under the term "medically necessary" include services required for maintaining health, preventing disease and/or diagnosing or treating an injury, illness or disability. No public consultation process is used.

13 new service codes were added during this reporting period.

- Laparoscopic Nephroureterectomy,
- Laparoscopic Pyeloplasty,
- Laparoscopic Nephrectomy,
- Laparoscopic Radical Nephrectomy,
- Laparoscopic Nephrectomy—etopic,
- CT Angiography—other than coronary,
- Pharmacologic Stress Test—solo procedure,
- Sentinel Node Biopsy,
- Sentinel Node Biopsy, in conjunction with another procedure—add-on,
- Insertion of Wall Stents including scope,
- Laparoscopic Nissen Fundoplication,
- Chronic Disease Management—COPD, and
- Needle Aponeurotomy.

2.3 Insured Surgical-Dental Services

Schedule 4 of Regulation 84-20 under the *Medical Services Payment Act* identifies the insured surgical-dental services that can be provided by a qualified dental practitioner in a hospital, providing the condition of the patient requires services to be rendered in a hospital.

In addition, a general dental practitioner may be paid to assist another dentist for medically required services under some conditions. In addition to Schedule 4 of Regulation 84-20, oral maxillofacial surgeons (OMS) have added access to approximately 300 service codes in the Physician Manual and can admit/discharge patients and perform physical examinations, including those performed in an out-patient setting. OMS may also see patients for consultation in their office.

As of March 31, 2012, there were 104 OMSs and dentists registered in New Brunswick OMSs and dentists have the same opting out provision as physicians (see section 2.2) and must follow the same guidelines. The Department has no data for the number of non-enrolled dental practitioners in New Brunswick.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include: patent medicines; take-home drugs; third-party requests for diagnostic services; visits to administer drugs; vaccines; sera or biological products;

televisions and telephones; preferred accommodation at the patient's request; and hospital services directly related to services listed under Schedule 2 of the Regulation under the *Medical Services Payment Act*. Services are not insured if provided to those entitled under other statutes.

The services listed in Schedule 2 of New Brunswick Regulation 84-20 under the *Medical Services Payment Act* are specifically excluded from the range of entitled medical services under Medicare. They are as follows:

- elective plastic surgery or other services for cosmetic purposes;
- correction of inverted nipple;
- breast augmentation;
- otoplasty for persons over the age of eighteen;
- removal of minor skin lesions, except where the lesions are, or are suspected to be, pre-cancerous;
- abortion, unless the abortion is performed by a specialist in the field of obstetrics and gynaecology in a hospital facility approved by the jurisdiction in which the hospital facility is located and two medical practitioners certify in writing that the abortion is medically required;
- surgical assistance for cataract surgery unless such assistance is required because of risk of procedural failure, other than risk inherent in the removal of the cataract itself, due to existence of an illness or other complication;
- medicines, drugs, materials, surgical supplies or prosthetic devices;
- vaccines, serum, drugs and biological products listed in sections 106 and 108 of New Brunswick Regulation 88-200 under the *Health Act*;
- advice or prescription renewal by telephone which is not specifically provided for in the Schedule of Fees;
- examination of medical records or certificates at the request of a third party, or other services required by hospital regulations or medical by-laws;
- dental services provided by a medical practitioner or an oral and maxillofacial surgeon;
- services that are generally accepted within New Brunswick as experimental or that are provided as applied research;
- services that are provided in conjunction with, or in relation to, the services referred to above;
- testimony in a court or before any other tribunal;
- immunization, examinations or certificates for purpose of travel, employment, emigration, insurance or at the request of any third party;
- services provided by medical practitioners or oral and maxillofacial surgeons to members of their immediate family;
- psychoanalysis;
- electrocardiogram (E.C.G.) where not performed by a specialist in internal medicine or paediatrics;
- laboratory procedures not included as part of an examination or consultation fee;
- refractions;
- services provided within the province by medical practitioners, oral and maxillofacial surgeons or dental practitioners for which the fee exceeds the amount payable under regulation;
- the fitting and supplying of eye glasses or contact lenses;
- trans-sexual surgery;
- radiology services provided in the province by a private radiology clinic;
- acupuncture;
- complete medical examinations when performed for the purposes of periodic check-up and not for medically necessary purposes;
- circumcision of a newborn;
- reversal of vasectomies;
- second and subsequent injections for impotence;
- reversal of tubal ligations;
- intrauterine insemination;
- bariatric surgery unless the person has a body mass index of 40 or greater or of 35 or greater but less than 40, as well as obesity-related comorbid conditions;
- venipuncture for purposes of taking blood when performed as a stand-alone procedure in a facility that is not an approved hospital facility.

Dental services not specifically listed in Schedule 4 of the Dental Schedule are not covered by the Plan. Those listed in Schedule 2 are considered the only non-insured medical services. There are no specific policies or guidelines, other than the Act and regulations, to ensure that charges for uninsured medical goods and services (i.e., fibreglass casts), provided in conjunction with an insured health service, do not compromise reasonable access to insured services. Intraocular lenses are now provided by the hospitals.

The decision to de-insure physician or surgical-dental services is based on the conformity of the service to the definition of "medically necessary," a review of medical service plans across the country, and the previous use of the particular service.

Once a decision to de-insure is reached, the *Medical Services Payment Act* dictates that the government may not make any changes to the Regulation until the advice and recommendations of the New Brunswick Medical Society are received or until the period within which the Society was requested by the Minister to furnish advice and make recommendations has expired. Subsequent to receiving their input and resolution of any issues, a regulatory change is completed. Physicians are informed in writing following notification of approval. The public is usually informed through a media release. No public consultation process is used.

In 2011–2012, no services were removed from the insured service list.

3.0 UNIVERSALITY

3.1 Eligibility

Sections 3 and 4 of the *Medical Services Payment Act* and Regulation 84-20 define eligibility for the health care insurance plan in New Brunswick.

Residents are required to complete a Medicare application and to provide proof of Canadian citizenship, Native status or a valid Canadian immigration document. A resident is defined as a person lawfully entitled to be, or to remain, in Canada, who makes his or her home and is ordinarily present in New Brunswick, but does not include a tourist, transient, or visitor to the province. As of March 31, 2012, there were 748,406 persons registered in New Brunswick.

All persons entering or returning to New Brunswick (excluding children adopted from outside Canada) have a waiting period before becoming eligible for Medicare coverage. Coverage commences on the first day of the third month following the month of arrival. Exceptions are as follows:

a) In June 2010, Regulation 84-20 under the *Medical Services Payment Act* was amended to state that dependents of Canadian Armed Forces personnel or their spouses moving from within Canada to New Brunswick will now be entitled to first day coverage under the program, provided they are deemed to have established permanent residence in New Brunswick.

b) In June 2010, Regulation 84-20 under the *Medical Services Payment Act* was amended to state that immigrants or Canadian residents moving or returning to New Brunswick will now be entitled to first day coverage, provided they are deemed to have established permanent residence in the province. Proper documentation is required (Immigration and Citizenship documentation) and decisions on coverage/residency are reviewed on a case-by-case basis.

Residents who were not eligible for Medicare coverage during this reporting period included:

- regular members of the Canadian Armed Forces;
- members of the Royal Canadian Mounted Police;
  - On June 29, 2012, as a result of the federal *Jobs, Growth and Long-term Prosperity Act*, the *Canada Health Act* was amended to allow members of the RCMP to be eligible for coverage under provincial and territorial health plans. At the time this report was compiled, federal, provincial and territorial governments were in consultation on the changes in provincial and territorial health legislation that would be required for members of the RCMP to be considered insured persons under provincial and territorial health insurance plans.
- inmates at federal institutions;
- temporary residents;
- a family member who moves from another province to New Brunswick before other family members move;
- persons who have entered New Brunswick from another province to further their education and who are eligible to receive coverage under the medical services plan of that province; and
- non-Canadians who are issued certain types of Canadian authorization permits (e.g., a Student Authorization).

Provisions to become eligible for Medicare coverage include:

- Non-Canadians who are issued an immigration permit that would not normally entitle them to coverage are eligible if legally married to, or in a common-law relationship with, a New Brunswick resident.

Provisions when status changes include:

- Persons who are discharged or released from the Canadian Armed Forces, the RCMP or a federal penitentiary. Provided they are residing in New Brunswick when discharged/released, these persons become eligible for coverage on the date of their discharge/release. An application must be completed, and the official date of release and proof of citizenship must be provided.

3.2 Other Categories of Individual

Non-Canadians who may be issued an immigration permit that would not normally entitle them to Medicare coverage are eligible provided that they are legally married to, or living in a common-law relationship with an eligible New Brunswick resident and still possess a valid immigration permit. At the time of renewal, they are required to provide an updated immigration document.

4.0 PORTABILITY

4.1 Minimum Waiting Period

A person is eligible for New Brunswick Medicare coverage on the first day of the third month following the month permanent residence has been established. The three month waiting period is legislated under New Brunswick's *Medical Services Payment Act*.

4.2 Coverage During Temporary Absences in Canada

The legislation that defines portability of health insurance during temporary absences in Canada is the *Medical Services Payment Act*, Regulation 84-20, sub-sections 3(4) and 3(5).

Medicare coverage is extended in the case of temporary absences to:

- students in full-time attendance at an educational institution outside New Brunswick;
- residents temporarily working in another jurisdiction; and
- residents whose employment requires them to travel outside the province.

Students

Those in full-time attendance at a university or other approved educational institution, who leave the province to further their education in another province, will be granted coverage for a twelve month period that is renewable, provided the following terms are met:

- proof of enrolment is provided;
- Medicare is contacted once every twelve months;
- permanent residence is not established outside New Brunswick; and
- health coverage is not received elsewhere.

Residents

Residents temporarily employed in another province or territory, are granted coverage for up to twelve months provided the following terms are met:

- permanent residence is not established outside New Brunswick; and
- health coverage is not received elsewhere.

New Brunswick has formal agreements for reciprocal billing arrangements of insured hospital services with all provinces and territories. In addition, New Brunswick has reciprocal agreements with all provinces, except Quebec, for the provision of insured physician services. Services provided by Quebec physicians to New Brunswick residents are paid at Quebec rates provided the service delivered is insured in New Brunswick. The majority of such claims are received directly from Quebec physicians. Any claims submitted directly by a patient are reimbursed to the patient.

4.3 Coverage During Temporary Absences Outside Canada

The legislation that defines portability of health insurance during temporary absences outside Canada is the *Medical Services Payment Act*, Regulation 84-20, subsections 3(4) and 3(5).

Eligibility for "temporarily absent" New Brunswick residents is determined in accordance with the *Medical Services Payment Act* and regulations and the Interprovincial Agreement on Eligibility and Portability.

Residents temporarily employed outside Canada are granted coverage for up to twelve months (regardless if it is known beforehand that they will be absent beyond the twelve month period), provided they do not establish residence outside Canada.

Any absence over one hundred and eighty-two days, whether it is for work purposes or vacation, would require the Director's approval. This approval can only be up to twelve months in duration and will only be granted once every three years. Families of workers temporarily employed outside Canada will continue to be covered, provided they reside in New Brunswick.

New Brunswick residents who exceed the twelve month extension have to reapply for New Brunswick Medicare upon their return to the province, and be subject to the legislated three month waiting period. However, a "grace period" of up to fourteen days may be extended to those residents who have been "temporarily absent" slightly beyond the twelve month period.

Insured residents who receive insured emergency services out-of-country are eligible to be reimbursed $100 per day for in-patient stays and $50 per out-patient visit. The insured resident is reimbursed for physician services associated with the emergency treatment at New Brunswick rates. The difference in rates is the patient's responsibility.

Mobile Workers

Mobile Workers are residents whose employment requires them to travel outside the province (e.g., pilots, truck drivers, etc.). Certain guidelines must be met to receive Mobile Worker designation. They are as follows:

- an application is to be submitted in writing;
- documentation is required as proof of Mobile Worker status (e.g., letter from employer confirming that frequent travel is necessary outside the province; a letter from the resident detailing their permanent residence as New Brunswick and the frequency of their return to the province; a copy of their New Brunswick driver's license; if working outside Canada, a copy of resident's immigration documents that allow them to work outside the country); and
- the worker must return to New Brunswick during their off-time.

Mobile Worker status is assigned for a maximum of two years, after which the resident must reapply and submit documentation to confirm a continuation of Mobile Worker status.

Contract Workers

Any New Brunswick resident accepting a contract out-of-country must supply the following information and documentation:

- a letter of request from the New Brunswick resident with their signature, detailing their absence, including Medicare number, address, departure and return dates, destination, forwarding address, and reason for absence; and
- a copy of a contractual agreement between employee and employer indicating start and end dates of employment.

Contract Worker status is assigned up to a maximum of two years. Any further requests for Contract Worker status must be forwarded to the Director of Medicare Eligibility and Claims for approval on an individual basis.

Students

Those in full-time attendance at a university or other approved educational institution in another country will be granted coverage for a twelve month period that is renewable, provided they comply with the following:

- proof of enrolment be provided;
- contact Medicare once every twelve months to retain eligibility;
- permanent residence is not established outside New Brunswick; and
- health coverage is not received elsewhere.

4.4 Prior Approval Requirement

Medicare may cover out-of-country services that are not available in Canada on a pre-approval basis only. Residents may opt to seek non-emergency out-of-country services; however, those who receive such services will assume responsibility for the total cost.

New Brunswick residents may be eligible for reimbursement if they receive elective medical services outside the country, provided the following requirements are met:

- the required service/equivalent or alternate service must not be available in Canada;
- the service must be rendered in a hospital listed in the current edition of the American Hospital Association Guide to the Health Care Field (guide to United States hospitals, health care systems, networks, alliances, health organizations, agencies and providers);
- the service must be rendered by a medical doctor; and
- the service must be an accepted method of treatment recognized by the medical community and be regarded as scientifically proven in Canada. Experimental procedures are not covered.

If the above requirements are met, it is mandatory to request prior approval from Medicare in order to receive coverage. A physician, patient or family member may request prior approval to receive these services outside the country, accompanied by supporting documentation from a Canadian specialist or specialists.

Out-of-country insured services that are not available in Canada, are non-experimental, and receive prior approval are paid in full. Often the amount payable is negotiated with the provider by the Canadian Medical Network on the province's behalf.

The following are considered exemptions under the out-of-country coverage policy:

- haemodialysis: patients will be required to obtain prior approval and Medicare will reimburse the resident at a rate equivalent to the inter-provincial rate of $472 per session; and
- allergy testing for environmental sensitivity: all tests outside the country will be paid at a maximum rate of $50 per day, an amount equivalent to an out-patient visit.

Prior approval is also required to refer patients to psychiatric hospitals and addiction centres outside the province because they are excluded from the Interprovincial Reciprocal Billing Agreement. A request for prior approval must be received by Medicare from the Addiction Services or Mental Health branches of the Department of Health.

5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

New Brunswick's health care system delivers quality care to the public it serves. New Brunswick does not charge user fees for insured health services as defined by the *Canada Health Act*. Therefore, all residents of New Brunswick have equal access to these services.

Access in a resident's official language of choice is not a limiting factor, regardless of where a resident receives services in the province.

5.2 Physician Compensation

Payments to physicians and dentists are governed under the *Medical Services Payment Act*, Regulations 84-20, 93-143 and 2002-53.

The methods used to compensate physicians for providing insured health services in New Brunswick are fee-for-service, salary and sessional or alternate payment mechanisms that may also include a blended system.

5.3 Payments to Hospitals

The legislative authorities governing payments to hospital facilities in New Brunswick are the *Hospital Act*, which governs the administration of hospitals, and the *Hospital Services Act*, which governs the financing of hospitals. The *Regional Health Authorities Act* provides for the delivery and administration of health services in defined geographic areas within the province.

The Department mainly distributes available funding to New Brunswick's regional health authorities (RHAs) through a Current Service Level approach. The funding base of the RHA from the previous year is the starting point, to which approved salary increases and a global inflator for non-wage items are added. This applies to all clinical services provided by hospital facilities, as well as support services (e.g., administration, laundry, food services, etc.). Funding for the Extra-Mural Program (home care) is also part of the RHA base.

Funding for FacilicorpNB, a shared services agency that manages the information technology, materials management and clinical engineering components of the hospital facilities in New Brunswick, is also based on the Current Service Level approach.

Any requests for funding for new programs/services are submitted to the Deputy Minister of Health for approval. Funding for approved new programs/services is based on requirements identified through discussions between Department of Health and RHA staff. These amounts are added to the RHA funding base once there is agreement on the funding requirements.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

New Brunswick routinely recognizes the federal role regarding its contributions under the Canada Health Transfer in public documentation presented through legislative and administrative processes. Federal transfers are identified in the Main Estimates document and in the Public Accounts of New Brunswick. Both documents are published annually by the New Brunswick government.

REGISTERED PERSONS					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
1. Number as of March 31st (#).	740,845	742,974	744,048	748,352	748,406

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
Public Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
2. Number (#).	50	53	56	57	56
3. Payments for insured health services ($).	1,372,911,800	1,449,216,237	1,590,399,994	1,616,340,008	1,721,356,342
Private For-Profit Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
4. Number of private for-profit facilities providing insured health services (#).[1]	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services ($).[1]	0	0	0	0	0

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
6. Total number of claims, in-patient (#).	4,363	3,919	4,036	4,537	3,925
7. Total payments, in-patient ($).	42,267,067	37,772,992	37,343,696	44,337,432	38,410,486
8. Total number of claims, out-patient (#).	51,406	46,824	49,005	44,444	32,310
9. Total payments, out-patient ($).	11,316,103	12,858,195	14,912,717	14,186,848	11,455,683
INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA					
10. Total number of claims, in-patient (#).	209	196	251	245	242
11. Total payments, in-patient ($).	726,650	753,104	556,678	607,147	808,783
12. Total number of claims, out-patient (#).	1,073	1,430	1,575	1,805	1,285
13. Total payments, out-patient ($).	441,575	561,855	883,980	798,355	857,130

1. There are no private for-profit facilities operating in New Brunswick.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
14. Number of participating physicians (#).[2]	1,453	1,500	1,571	1,588	1,618
15. Number of opted-out physicians (#).	0	0	0	0	0
16. Number of non-participating physicians (#).	0	0	0	0	0
17. Total payments for services provided by physicians paid through all payment methods ($).[3]	421,547,901	441,197,899	505,899,089	538,111,685	543,148,047
18. Total payments for services provided by physicians paid through fee-for-service ($).	254,454,602	260,939,796	273,030,951	279,663,511	306,092,105

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
19. Number of services (#).	213,710	197,023	266,918	209,868	182,746
20. Total payments ($).	11,998,933	11,607,119	16,206,261	11,965,539	13,221,951
INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA					
21. Number of services (#).	5,990	4,175	5,885	4,610	5,072
22. Total payments ($).	487,679	341,618	440,957	568,937	635,020

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
23. Number of participating dentists (#).[4]	21	26	26	14	23
24. Number of services provided (#).	2,962	3,323	3,363	2,722	2,859
25. Total payments ($).	598,383	571,175	385,796	367,905	712,367

2. These are the number of physicians with an active physician status on March 31st of each year.
3. The Total Payment for all payment methods is a preliminary figure and includes budgeted amounts for alternate funding plans. Fee-for-service is for automated fee-for-service only.
4. These are the number of Dentists and Oral Maxillofacial Surgeons (OMS) participating in New Brunswick's Medical Services Plan during each fiscal year. In 2011–2012, of the 104 dentists and OMSs registered, 23 billed the Medical Services Plan.

QUEBEC

1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

Quebec's hospital insurance plan, the Régime d'assurance hospitalisation du Québec, is administered by the Ministère de la Santé et des Services Sociaux (MSSS) (the Quebec Ministry of Health and Social Services).

Quebec's health insurance plan, the Régime d'assurance maladie du Québec, is administered by the Régie de l'assurance maladie du Québec (Régie) (the Quebec Health Insurance Board), a public body established by the provincial government that reports to the Minister of Health and Social Services.

1.2 Reporting Relationship

The *Public Administration Act* (R.S.Q., c. A-6.01) sets forth the government criteria for preparing reports on the planning and performance of public authorities, including the Ministère de la Santé et des Services Sociaux and the Régie de l'assurance maladie du Québec.

1.3 Audit of Accounts

Both plans (the Quebec hospital insurance plan and the Quebec health insurance plan) are operated on a non-profit basis. All books and accounts are audited by the auditor general of the province.

2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

Insured in-patient services include the following: standard ward accommodation and meals; necessary nursing services; routine surgical supplies; diagnostic services; use of operating rooms, delivery rooms and anaesthetic facilities; medication; prosthetic and orthotic devices that can be integrated with the human body; biological products and related preparations; use of radiotherapy, radiology and physiotherapy facilities; and services delivered by hospital staff.

Out-patient services include the following: clinical services for psychiatric care; electroshock, insulin and behaviour therapies; emergency care; minor surgery (day surgery); radiotherapy; diagnostic services; physiotherapy; occupational therapy; inhalation therapy, audiology, speech therapy and orthoptic services; and other services or examinations required under Quebec legislation.

Other insured services are: mechanical, hormonal or chemical contraception services; surgical sterilization services (including tubal ligation or vasectomy); reanastomosis of the fallopian tubes or vas deferens; and extraction of a tooth or root when the patient's health status makes hospital services necessary.

The MSSS administers an ambulance transportation program that is free of charge to persons aged 65 or older.

In addition to basic insured health services, the Régie also covers the following, with some limitations, for certain residents of Quebec, as defined by the *Health Insurance Act* (R.S.Q. c. A-29), and for employment assistance recipients: optometric services; dental care for children and employment assistance recipients, and acrylic dental prostheses for employment assistance recipients; prostheses, orthopaedic appliances, locomotion and postural aids, and other equipment that helps with a physical disability; external breast prostheses; ocular prostheses; hearing aids, assistive listening devices and visual aids for people with a visual or auditory disability; and permanent ostomy appliances.

With regard to drug insurance, since January 1, 1997, the Régie has covered, in addition to its regular clientele (employment assistance recipients and persons 65 years of age or older), Quebec residents who would not otherwise have access to a private drug insurance plan. In 2011–2012, the drug insurance plan covers 3.4 million insured persons.

2.2 Insured Physician Services

Services insured under this plan include medical and surgical services that are provided by physicians and are medically necessary.

Family planning services set forth by legislation and provided by a physician are insured, as are assisted reproduction services set forth by legislation.

2.3 Insured Surgical-Dental Services

Services insured under this plan include oral surgery performed by dental surgeons and specialists in oral and maxillo-facial surgery, in a prescribed hospital centre or university institution.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include: plastic surgery; a private or semi-private room at the patient's request; televisions; telephones; drugs and biological products ordered after discharge from hospital; and services for which the patient is covered under the Act respecting industrial accidents and occupational diseases or other federal or provincial legislation.

The following services are not insured: any examination or service not related to a process of curing or preventing illness; psychoanalysis of any kind, unless such service is delivered in a facility maintained by an institution authorized for such purpose by the Minister of Health and Social Services; any service provided solely for aesthetic purposes; any refractive surgery, except where there is documented failure in respect of corrective lenses and contact lenses for astigmatism of more than 3.00 diopters or anisometropia of more than 5.00 diopters measured from the cornea; any consultation by telecommunication or by correspondence; any service delivered by a professional to his or her spouse or children; any examination, expert appraisal, testimony, certificate or other formality required for legal purposes or by a person other than one who has received an insured service, except in certain cases; any visit made for the sole purpose of obtaining the renewal of a prescription; any examinations, vaccinations, immunizations or injections, where the service is provided to a group or for certain purposes; any service delivered by a professional on the basis of an agreement or contract with an employer, association or body; any adjustment of eyeglasses or contact lenses; any surgical extraction of a tooth or dental fragment performed by a physician, unless such a service is provided in a hospital centre in certain cases; all acupuncture procedures; injection of sclerosing substances and the examination performed at that time; mammography used for detection purposes, unless this service is required by medical prescription in a place designated by the Minister to a recipient 35 years of age or older, provided that the person has not been so examined for one year; thermography, tomodensitometry, magnetic resonance imaging and use of radionuclides in vivo in humans, unless these services are delivered in a hospital centre; ultrasonography, unless this service is delivered in a hospital centre or, for obstetrical purposes, in a local community service centre (CLSC) recognized for that purpose; optical tomography of the eyeball and confocal scanning laser ophthalmoscopy of the optic nerve, unless these services are delivered in a facility maintained by an institution that operates a hospital or are delivered in association with the delivery, by intravitreal injection, of an antiangiogenic drug for the treatment of age-related macular degeneration; any radiological or anaesthetic service provided by a physician if required for providing an uninsured service, with the exception of a dental service provided in a hospital centre or, in the case of radiology, if required by a person other than a physician or dentist; any sex-reassignment surgery, unless it is provided on the recommendation of a physician specializing in psychiatry and is provided in a hospital centre recognized for this purpose; and any services that are not related to pathology and that are delivered by a physician to a patient between 18 and 65 years of age, unless that individual is the holder of a claim booklet, for colour blindness or a refractive error, in order to provide or renew a prescription for eyeglasses or contact lenses.

3.0 UNIVERSALITY

3.1 Eligibility

Registration with the hospital insurance plan is not required. Registration with the Régie de l'assurance maladie du Québec or proof of residence is sufficient to establish an individual's eligibility. Any individual residing or staying in Quebec as defined in the *Health Insurance Act* must be registered with the Régie de l'assurance maladie du Québec to be eligible for hospital services.

3.2 Other Categories of Individuals

Services received by regular members of the Canadian Forces, members of the Royal Canadian Mounted Police (RCMP) and inmates of federal penitentiaries are not covered by the plan. There are no health premium charges.

Certain categories of residents, notably permanent residents under the *Immigration Act* and persons returning to live in Canada, become eligible under the plan following a waiting period of up to three months. Persons receiving last resort financial assistance benefits are eligible upon registration. Members of the Canadian Forces and RCMP who have not acquired the status of resident of Quebec, and inmates of federal penitentiaries become eligible the day they are discharged or released. Immediate coverage is provided for certain seasonal workers, repatriated Canadians, persons from outside Canada who are living in Quebec under an official bursary or internship program of the Ministère de l'Éducation (the Quebec Ministry of Education), persons from outside Canada who are eligible under an agreement or accord reached with a country or an international organization, and refugees. Persons from outside Canada who have work permits and are living in Quebec for the purpose

of holding an office or employment for a period of more than six months become eligible for the plan following a waiting period.

4.0 PORTABILITY

4.1 Minimum Waiting Period

Persons settling in Quebec after moving from another province of Canada are entitled to coverage under the Quebec health insurance plan when they cease to be entitled to benefits from their province of origin, provided they register with the Régie.

4.2 Coverage During Temporary Absences In Canada

If living outside Quebec in another province or territory for 183 days or more, and provided they notify the Régie of this, students and full-time unpaid trainees may retain their status as residents of Quebec: students for a maximum of four consecutive calendar years, and full-time unpaid trainees for a maximum of two consecutive calendar years.

This is also the case for persons living in another province or territory who are temporarily employed or working on contract there. Their resident status can be maintained for no more than two consecutive calendar years.

Persons directly employed or working on contract outside of Quebec for a company or corporate body with its headquarters or a place of business in Quebec, to which they report directly, or employed by the federal government and posted outside Quebec, also retain their status as a resident of the province. The same is true of persons who remain outside the province 183 days or more, but less than 12 months within a calendar year, provided such absence occurs only once every seven years.

The costs of medical services received in another province or territory of Canada are reimbursed at the amount actually paid or the rate that would have been paid by the Régie for such services in Quebec, whichever is less. However, Quebec has negotiated a permanent arrangement with Ontario to pay Ottawa doctors at the Ontario fee rate for specialized services that are not available in the Outaouais region. This agreement came into effect on November 1, 1989. The Régie covers the amount it would have paid for the same services in Quebec. The Agence de la santé et des services sociaux de l'Outaouais (Outaouais health and social services agency) pays the difference between the cost invoiced by Ontario and the amount initially reimbursed by the Régie. A similar agreement was signed in December 1991 between the Centre de santé Témiscaming (Témiscaming Health Centre) and North Bay.

Costs of hospital services with which a recipient is provided in another province or territory of Canada are paid in accordance with the terms and conditions of the agreement on reciprocal billing of insured services regarding hospital insurance agreed to by the provinces and territories of Canada. These costs are paid either at the established per diem for hospitalization in a standard ward or in intensive care proposed by the host province and approved by all the provinces and territories or, in cases of out-patient services or expensive procedures, at the approved interprovincial rates. Insured persons who leave Quebec to settle in another province or territory of Canada are covered for up to three months after leaving the province.

4.3 Coverage During Temporary Absences Outside Canada

Students, unpaid trainees, Quebec government officials posted abroad and employees of non-profit organizations working in international aid or cooperation programs recognized by the Minister of Health and Social Services must contact the Régie to determine their eligibility. If the Régie grants them special status, they receive full reimbursement of hospital costs in case of emergency or sudden illness, and 75 percent reimbursement in other cases.

As of September 1, 1996, hospital services provided outside Canada in case of emergency or sudden illness are reimbursed by the Régie, usually in Canadian funds, to a maximum of C$100 per day if the patient was hospitalized (including in the case of day surgery) or to a maximum of C$50 per day for out-patient services.

However, haemodialysis treatments are covered to a maximum of C$220 per treatment, including medications, whether the patient is hospitalized or not. In these cases, the Régie covers the associated professional services at the lowest cost, either the amount actually paid or what would have been paid by the Régie for the same services in Quebec. The services must be delivered in a hospital or hospital centre recognized and accredited by the appropriate authorities. No reimbursements are made for nursing homes, spas or similar establishments.

Costs for insured services provided by physicians, dentists, oral surgeons and optometrists are reimbursed at the rate that would have been paid by the Régie to a health professional recognized in Quebec, up to the amount of the expenses actually incurred. When they are delivered abroad, all services insured by the Régime d'assurance maladie are reimbursed at the Quebec rate, usually in Canadian funds.

An insured person who moves permanently from Quebec to another country ceases to be a recipient on the day of departure.

Residents of Quebec who are working or studying abroad are covered by the plan in effect in that country, when the stay falls under a social security agreement reached between the Minister of Health and Social Services and the country in question.

4.4 Prior Approval Requirement

Insured persons requiring medical services in hospitals elsewhere in Canada or abroad that are not available in Quebec are reimbursed 100 percent if prior consent has been given for medical and hospital services that meet certain conditions. Consent is not given by the Plan's officials if the medical service in question is available in Quebec.

5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

Everyone has the right to receive adequate health care services without any kind of discrimination. There is no extra-billing by Quebec physicians.

On March 31, 2012, Quebec had 113 institutions operating as hospital centres for a clientele suffering from acute illnesses. On that date, 20,658 beds for persons requiring short-term care for general or specialized ailments were allotted to these institutions. According to the most recent available data, from April 1, 2010, to March 31, 2011, Quebec hospital institutions had 725,426 admissions for short stays (including newborns) and 366,560 registrations for day surgeries. These hospitalizations accounted for 5,189,506 patient days.

Since 2003, the Quebec health care system has been based on local services networks covering the entire province. At the core of each of these local networks is the Health and Social Services Centre (CSSS). The centres are the result of the merger of the public institutions whose mission it was to provide CLSC (local community service centre) services, CHSLD (residential and long-term care) services and, in most cases, neighbourhood hospital services. CSSSs must also provide the people in their territory with access to other medical services, general and specialized hospital services, and social services. To do so, they must enter into service agreements with other health sector organizations. The linking of services within a territory forms the local services network. Thus, the aim of integrated local health and social services networks is to make all the stakeholders in a given territory collectively responsible for the health and well-being of the people in that territory.

Since 2003–2004, there have been family medicine groups (FMGs). An FMG is a group of doctors working as a team and in close collaboration with nurses and other CSSS professionals to provide services ranging from assessment of health status to case management, monitoring, diagnosis and treatment of acute and chronic problems, and disease prevention. Their services include medical consultations with and without an appointment, seven days a week, and an adapted response to people whose health status requires special arrangements for access to services. As of March 31, 2012, there were 239 accredited FMGs and 49 network-clinics in Quebec.

5.2 Physician Compensation

Physicians are remunerated in accordance with the negotiated fee schedule. Physicians who have withdrawn from the health insurance plan are paid directly by the patient according to the fee schedule after the patient has collected from the Régie. Non-participating physicians are paid directly by their patients according to the amount charged. The Minister may enter into an agreement with the organizations representing any class of health professional. This agreement may prescribe a different rate of compensation for medical services in a territory where the number of professionals is considered insufficient.

While the majority of physicians practise within the provincial plan, Quebec allows two other options: professionals who have withdrawn from the plan and practise outside the plan, but agree to remuneration according to the provincial fee schedule; and non-participating professionals who practise outside the plan, with no reimbursement from the Régie going to either them or their patients.

According to the most recent data available, in 2011–2012 the Régie paid an estimated $5,513.2 million to doctors in the province, while the amount for medical services outside the province reached an estimated $13.2 million.

5.3 Payments to Hospitals

The Minister of Health and Social Services funds hospitals through payments directly related to the cost of insured services provided.

The payments made in 2011-2012 to institutions operating as hospital centres for insured health services provided to residents of Quebec totalled nearly $10.4 billion. Payments to hospital centres outside Quebec for hospital services totalled approximately $185.62 million.

ONTARIO

INTRODUCTION

Ontario has one of the largest and most complex publicly-funded health care systems in the world. Administered by the province's Ministry of Health and Long-Term Care, Ontario's health care system was supported by over $47.2 billion (including capital) in spending for 2011–2012.

The Ministry provides services to the public through such programs as health insurance, drug benefits, assistive devices, forensic mental health and supportive housing, long-term care, home care, community and public health, and health promotion and disease prevention. It also regulates hospitals and nursing homes, operates medical laboratories, and coordinates emergency health services.

Fourteen Local Health Integration Networks (LHINs) plan, fund and integrate local health care services. With the LHINs responsible for local health care management, the Ministry assumes a stewardship role by establishing overall strategic direction and priorities for the provincial health care system.

1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

Ontario Health Care and Health Care Planning

The Ontario Health Insurance Plan (OHIP) is administered on a non-profit basis by the Ministry of Health and Long-Term Care (MOHLTC). OHIP was established in 1972 and is continued under the *Health Insurance Act*, Revised Statutes of Ontario, 1990, c. H-6, to provide insurance in respect of the cost of insured services provided to Ontario residents (as defined in the *Health Insurance Act*) in hospitals and health facilities, and by physicians and other health care practitioners.

Local Health Integration Networks (LHINs) were established under the *Local Health System Integration Act*, 2006 (LHSIA) to improve Ontarians' health through better access to high-quality health services, coordinated health care, and effective and efficient management of the health system at the local level. On April 1, 2007, the LHINs assumed responsibility for funding, planning and integrating health care services at the local level. These include services delivered by hospitals, community care access centres, long-term care homes, community health centres, community support services, and mental health and addictions agencies.

LHSIA also reaffirms the principles of the *French Language Services Act* to ensure equitable access to services in French for French-speaking Ontarians.

1.2 Reporting Relationship

The *Health Insurance Act* stipulates that the Minister of Health and Long-Term Care is responsible for the administration and operation of OHIP, and is Ontario's public authority for the purposes of the *Canada Health Act*.

LHSIA requires each LHIN to prepare an annual report on its affairs and operations for the previous fiscal year. The Agency Establishment and Accountability Directive (AEAD), more specifically, requires that every operational service agency (including LHINs) prepare an annual report. The Minister is required to table the reports in the Legislative Assembly of Ontario.

The Ministry has a performance agreement with each LHIN that includes obligations, measures and targets for the networks. The agreements also include the funding allocations by sector. LHSIA provides the LHINs with the authority to fund defined health service providers and to enter into service accountability agreements with health service providers.

1.3 Audit of Accounts

Every year the Auditor General of Ontario reports on the results of his examination of government resources and administration. The Auditor General's report is tabled by the Speaker of the Legislative Assembly, usually in the fall, at which time it becomes available to the public. Audit reports on select areas of the Ministry chosen for review by the Auditor General in any given year are included within this annual report, the last of which was released on December 5, 2011.

The Ministry's accounts and transactions are published annually in the Public Accounts of Ontario. The 2011–2012 Public Accounts of Ontario was released on September 13, 2012.

2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

Insured in-patient and out-patient hospital services in Ontario are prescribed under the *Health Insurance Act*, and Regulation 552 under the Act.

Insured in-patient hospital services[1] include medically required: use of operating rooms, obstetrical delivery rooms and anaesthetic facilities; necessary nursing services; laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability; drugs, biologicals and related preparations; and accommodation and meals at the standard ward level.

Insured out-patient services include medically required: laboratory, radiological and other diagnostic procedures; use of radiotherapy, occupational therapy, physiotherapy and speech therapy facilities, where available; use of diet counselling services; use of the operating room, anaesthetic facilities; surgical supplies; necessary nursing service; supply of drugs, biologicals, and related preparations (subject to some exceptions) and certain other specified services, for example, the provision of equipment, supplies and medication to haemophiliac patients for use at home; and certain specified home-administered drugs.

2.2 Insured Physician Services

Insured physician services are prescribed under the *Health Insurance Act* and regulations under the Act.

Under section 11.2 of the *Health Insurance Act* and subsection 37.1(1) of Regulation 552 to the *Health Insurance Act*, a service provided by a physician in Ontario is an insured service if it is medically necessary; referred to in the Schedule of Benefits—Physician Services; and rendered in such circumstances or under such conditions as specified in the Schedule of Benefits. Physicians provide medical, surgical and diagnostic services, including primary health care services. Services are provided in a variety of settings, including: private physician offices, community health centres, hospitals, mental health facilities, licensed independent health facilities, and long-term care homes.

In general terms, insured physician services include: diagnosis and treatment of medical disabilities and conditions; medical examinations and tests; surgical procedures; maternity care; anaesthesia; radiology and laboratory services in approved facilities; and immunizations, injections and tests.

The Schedule of Benefits is regularly reviewed and revised to reflect current medical practice and new technologies. New services may be added, existing services revised, or obsolete services removed through regulatory amendment. This process involves consultation with the Ontario Medical Association.

During 2011–2012, most physicians submitted claims for all insured services rendered to insured persons directly to the Ontario Health Insurance Plan (OHIP), in accordance with section 15 of the *Health Insurance Act*, or a limited number could bill the insured person, as permitted by section 15.2 of the Act (see also Part II of the Commitment to the *Future of Medicare Act*). Physicians who do not bill OHIP directly are commonly referred to as having "opted out." When a physician has opted out, the physician bills the patient (not exceeding the amount payable for the service under the Schedule (on a "grandparented" basis as of May 13, 2004) following proclamation of the *Commitment to the Future of Medicare Act* on September 23, 2004.

Physicians must be registered to practice medicine in Ontario by the College of Physicians and Surgeons of Ontario, and be located in Ontario when rendering the service.

There were approximately 26,818 physicians who submitted claims to OHIP in 2011–2012. This figure includes physicians submitting both fee-for-service claims and physicians included in an alternative payment plan who submitted tracking or shadow-billed claims.

2.3 Insured Surgical-Dental Services

Certain surgical-dental services are prescribed as insured services in section 16 of Regulation 552 in the *Health Insurance Act* and the Dental Schedule of Benefits. The *Health Insurance Act* authorizes OHIP to cover a limited number of procedures when the procedure is medically necessary, and it is medically necessary that the insured services be performed in a public hospital graded under the *Public Hospitals Act* as Group A, B, C or D by a dental surgeon who has been appointed to the dental staff of the public hospital.

Insured surgical-dental services were provided by 262 dental surgeons in Ontario in 2011–2012.

1. A complete list of hospital services is set out in sections 7-11 of Regulation 552 under the *Health Insurance Act*.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital services include but are not limited to: private or semi-private accommodation unless prescribed by a physician, oral-maxillofacial surgeon or midwife; telephones and televisions; charges for certain private-duty nursing; and provision of medications for patients to take home from hospital, with prescribed exceptions.

Section 24 of Regulation 552 details some specified physician and supporting services that are not insured services.

Uninsured physician services include, among others: services that are not medically necessary; the preparation or provision of a drug, antigen, antiserum or other substance, unless the drug, antigen or antiserum is used to facilitate a procedure or examination; advice given by telephone at the request of the insured person or the person's representative; the preparation and transfer of records at the insured person's request; a service that is received wholly or partly for producing or completing a document or transmitting information to a "third party" in prescribed circumstances; the production or completion of a document or transmission of information to any person other than the insured person in prescribed circumstances; provision of a prescription when no concomitant insured service is rendered; acupuncture procedures; psychological testing; research and survey programs; experimental treatment; and toll charges for long-distance telephone calls.

3.0 UNIVERSALITY

3.1 Eligibility

Section 11 of the *Health Insurance Act* specifies that every person who is a resident of Ontario is entitled to become an insured persion under the Ontario Health Insurance Plan (OHIP) upon application. To be considered a resident of Ontario for the purpose of obtaining Ontario health insurance coverage, Regulation 552 to the *Health Inusrance Act* requires that a person must:

- hold Canadian citizenship or an immigration status as prescribed in Regulation 552 under the *Health Insurance Act*;
- make his or her primary place of residence in Ontario;
- subject to some limited exceptions, be physically present in Ontario for at least 153 days in any 12-month period; and
- for most new and returning residents, be physically present in Ontario for 153 of the first 183 days following the date residence is established in Ontario (i.e., a person cannot be away from the province for more than 30 days in the first six months of residency).

Individuals who are not eligible for OHIP coverage are those who do not meet the definition of a resident, including those who do not hold an immigration or other status that is set out in Regulation 552, such as tourists, transients and visitors to the province. Services that a person is entitled to receive under federal legislation are not insured services (i.e., those provided to federal penitentiary inmates and Canadian Forces members).

Persons who were previously ineligible for Ontario health insurance coverage but whose status and/or residency situation has changed (e.g., change in immigration status), may be eligible upon application and subject to the requirements of Regulation 552.

When it is determined that a person is not eligible or is no longer eligible for OHIP coverage, a request may be made to the Ministry of Health and Long-Term Care (MOHLTC) to review the decision. Anyone may request that the Ministry review the denial of their OHIP eligibility by making a request in writing to the OHIP Eligibility Review Committee. Further, those who are not satisfied with the decision regarding their OHIP eligibility may request an appeal of their case by the Health Services Appeal and Review Board.

MOHLTC is the sole payor for OHIP insured physician, hospital and hospital dental-surgical services. An eligible Ontario resident may not obtain any benefits from another insurance plan for the cost of any insured service that is covered by OHIP (with the exception of during the OHIP waiting period).

Approximately 13.2 million Ontario residents were registered with OHIP and held valid and active health cards as of March 31, 2012.

3.2 Other Categories of Individual

MOHLTC provides health insurance coverage to residents of Ontario other than Canadian citizens and Permanent Residents/Landed Immigrants.

These residents are required to provide acceptable documentation to support their eligible immigration status, their residence in Ontario, and their identity in the same manner as Canadian citizens or Permanent Resident/Landed Immigrant applicants.

The individuals listed below who are resident in Ontario may be eligible for Ontario health insurance coverage in accordance with Regulation 552 of the *Health Insurance Act*. Individuals are required to apply in person to register for Ontario health insurance coverage. Registration for OHIP is provided by ServiceOntario, which has the government-wide mandate for the delivery of front-facing services to the residents of Ontario, which also includes the issuance of the Ontario Photo Health Card.

Applicants for Permanent Residence: These are persons who have submitted an application for Permanent Resident status to Citizenship and Immigration Canada (CIC) and CIC has confirmed that the person meets the eligibility requirements to apply for permanent residence in Canada and that the application has not yet been denied.

Protected Persons: These are persons who are determined to be Protected Persons under the terms of the federal *Immigration and Refugee Protection Act*. Members of this group are provided with immediate Ontario health insurance coverage.

Holders of Temporary Resident Permits: A Temporary Resident Permit is issued to an individual by CIC when there are compelling reasons to admit an individual into Canada who would otherwise be inadmissible under the federal *Immigration and Refugee Protection Act*. Each Temporary Resident Permit has a case type or numerical designation on the permit that indicates the circumstances allowing the individual entry into Canada. Individuals who hold a permit with a case type of 86, 87, 88, 89, 90, 91, 92, 93, 94, 95 or 80 (if for adoption) are eligible for Ontario health insurance coverage. Individuals who hold a permit with a case type of 80 (except for adoption), 81, 84, 85 and 96 are not eligible for Ontario health insurance coverage.

Clergy, Foreign Workers and their Accompanying Family Members: An eligible foreign clergy is a person who is sponsored by a religious organization or denomination if the member has finalized an agreement to minister to a religious congregation or group in Ontario for at least six months, as long as the member is legally entitled to stay in Canada.

A foreign worker is eligible for Ontario health insurance coverage if the individual has been issued a Work Permit or other document by CIC that permits the person to work in Canada if the person also has a formal agreement in place to work full-time for an employer in Ontario. The work permit/other document issued by CIC, or a letter provided by the employer, must set out the employer's name, state the person's occupation with the employer, and state that the person will be working for the employer for no less than six consecutive months.

A spouse and/or dependant (under 22 years of age; or 22 years of age or older, if dependent due to a mental or physical disability) of an eligible foreign member of the clergy or an eligible foreign worker is also eligible for Ontario health insurance coverage as long as the spouse or dependant is legally entitled to stay in Canada.

Live-in Caregivers: Eligible live-in caregivers are persons who hold a valid Work Permit under the Live-in Caregiver Program (LCP) administered by the Government of Canada. The Work Permit for LCP workers does not have to list the three specific employment conditions required for all other foreign workers.

Applicants for Canadian Citizenship: These individuals are eligible for Ontario health insurance coverage if they have submitted an application for Canadian citizenship under section 5.1 of the federal *Citizenship Act*, even if the application has not yet been approved, provided that CIC has confirmed that the person meets the eligibility requirements to apply for citizenship under that section and the application has not yet been denied.

Seasonal Agricultural Farm Workers: Seasonal Agricultural Farm Workers are persons who have been issued a Work Permit under the Seasonal Agricultural Worker Program administered by the Government of Canada. Due to the special nature of their employment, migrant farm workers do not have to meet any other residency requirement and are provided with immediate Ontario health insurance coverage.

Children Born Out-of-Country: A child born to an OHIP-eligible woman who was transferred from Ontario to receive insured health services that were pre-approved for payment by OHIP is eligible for immediate OHIP coverage provided that the mother was pregnant at the time of departure from Ontario.

3.3 Premiums

No premiums are required to obtain Ontario health insurance coverage. There is an Ontario Health Premium that is collected through the provincial income tax system but it is not connected to OHIP registration or eligibility in any way. Responsibility for the administration of the Ontario Health Premium lies with the Ontario Ministry of Finance.

4.0 PORTABILITY

4.1 Minimum Waiting Period

In accordance with section 5 of Regulation 552 under the *Health Insurance Act*, individuals who move to Ontario are typically entitled to Ontario Health Insurance Plan (OHIP) coverage three months after establishing residency in the province unless listed as an exception in sections 6, 6.1, 6.2, 6.3 of the Regulation, or section 11(2.1) of the *Health Insurance Act*.

In accordance with section 5 of Regulation 552 under the *Health Insurance Act* and as provided for in the Interprovincial Agreement on Eligibility and Portability, persons who permanently move to Ontario from another Canadian province or territory where they were insured will typically be eligible for OHIP coverage after the last

day of the second full month following the date residency is established (i.e., an "interprovincial waiting period").

Assessment of whether or not an individual is subject to the interprovincial waiting period occurs at the time of their application for Ontario health insurance coverage. Examples of those who are exempt from the three-month waiting period in accordance with the *Health Insurance Act* and its regulations include newborn babies, eligible military family members, and insured residents from another province or territory who move to Ontario and immediately become residents of an approved long-term care home in Ontario.

4.2 Coverage During Temporary Absences in Canada

Insured out-of-province services are prescribed under sections 28, 28.0.1, and 29 to 32 of Regulation 552 of the *Health Insurance Act*.

Ontario adheres to the terms of the Interprovincial Agreement on Eligibility and Portability; therefore, insured residents who are temporarily outside of Ontario can use their Ontario health cards to obtain insured physician (except in Quebec) and hospital services.

An insured person who leaves Ontario temporarily to travel within Canada, without establishing residency in another province or territory, may continue to be covered by OHIP for a period of up to 12 months.

An insured person who temporarily seeks or accepts employment in another province or territory may continue to be covered by OHIP for a period of up to 12 months. If the individual plans to remain outside Ontario beyond the 12-month maximum, he or she should apply for coverage in the province or territory where that person has been working or seeking work.

Insured students who are temporarily absent from Ontario, but remain within Canada, may be eligible for continuous health insurance coverage for the duration of their full-time studies, provided they do not establish permanent residency elsewhere during this period. To ensure that they maintain continuous OHIP eligibility, a student should provide the Ministry of Health and Long-Term Care (MOHLTC) with documentation from their educational institution confirming registration as a full-time student. Insured family members (spouses and dependants) of students who are studying in another province or territory are also eligible for continuous OHIP eligibility while accompanying students for the duration of their studies.

In accordance with Regulation 552 of the *Health Insurance Act*, most insured residents who want to travel, work or study outside Ontario, but within Canada, and maintain OHIP coverage, must have resided in Ontario for at least 153 days in the last 12-month period immediately prior to departure from Ontario.

Ontario participates in Reciprocal Hospital Billing Agreements with all other provinces and territories for insured in-patient and out-patient hospital services. Payment is at the agreed upon in-patient rate of the plan in the province or territory where hospitalization occurs.

Ontario pays the standard out-patient charges set out by the Interprovincial Health Insurance Agreements Coordinating Committee. Ontario also participates in the Physicians' Reciprocal Billing Agreements with all other provinces and territories, except Quebec (which has not signed a reciprocal agreement with any other province or territory), for insured physician services. Ontario residents who may be required to pay for physician services received in Quebec can submit their receipts to MOHLTC for payment as an insured service at Ontario rates.

4.3 Coverage During Temporary Absences Outside Canada

Health insurance coverage for insured Ontario residents during extended absences (longer than 212 days) outside Canada is governed by sections 1.7 through 1.14 of Regulation 552 of the *Health Insurance Act*.

The Ministry requests that residents apply to MOHLTC to confirm this coverage before their departure and provide documents explaining the reason for their absence.

In accordance with the regulations and MOHLTC policy, most applicants must also have been resident in Ontario for at least 153 days in each of the two consecutive 12-month periods before their expected date of departure.

The length of time that a person can receive continuous Ontario health insurance coverage during an extended absence outside Canada varies depending on the reason for the absence as follows:

REASON	OHIP COVERAGE
Study	Duration of full-time academic studies (unlimited)
Work	Five-year terms (specific residency requirements must be met for 2 years between absences)
Charitable Worker	Five-year terms (specific residency requirements must be met for 2 years between absences)
Vacation/Other	Two-year terms (specific residency requirements must be met for 5 years between absences)

Certain family members may also qualify for continuous Ontario health insurance coverage while accompanying the primary applicant on an extended absence outside Canada.

Payment of out-of-country services are covered under sections 28.1 to 28.6 inclusive, and sections 29 and 31 of Regulation 552 of the *Health Insurance Act*.

Out-of-country emergency hospital costs are reimbursed at Ontario fixed per diem rates of:

- a maximum $400 (CAD) for in-patient services for the level of care described in the Regulations and $200 (CAD) for any other level of care;
- a maximum $50 (CAD) for out-patient services (except dialysis); and
- a maximum of $210 (CAD) for out-patient services that include renal dialysis.

During 2011–2012, emergency, medically necessary, out-of-country physician services were reimbursed at the Ontario rates set out in regulation under the *Health Insurance Act* or the amount billed, whichever was less. Charges for medically necessary emergency or out-of-country in-patient and out-patient services are reimbursed only when rendered in an eligible hospital or health facility. Medically necessary out-of-country laboratory services, when done on an emergency basis by a physician, are reimbursed in accordance with the formula set out in section 29(1)(b) of the Regulation or the amount billed, whichever is less, and when done on an emergency basis by a laboratory, in accordance with the formula set out in section 31 of the Regulation.

4.4 Prior Approval Requirement

As set out in section 28.4 of Regulation 552 under the *Health Insurance Act*, written prior approval from MOHLTC is required for payment for non-emergency health services provided outside of Canada prior to the medical services being rendered. Where the identical or equivalent service is not performed in Ontario, or where the patient faces a delay in accessing the service in Ontario that would result in death or medically significant irreversible tissue damage, the patient may be entitled to full funding for out-of-country insured health services.

Generally speaking, the prior approval application must establish that the services or tests are:

- medically necessary;
- the identical or equivalent service is not performed in Ontario, or the identical or equivalent service is performed in Ontario but it is necessary that the insured person travel out of Canada to avoid a delay that would result in death or medically significant irreversible tissue damage;
- generally accepted by the medical profession in Ontario as appropriate for a person in the same circumstances as the insured person;
- not experimental;
- not performed for research purposes or survey; and
- written prior approval of payment is granted by the General Manager before any of the health services are rendered.

There are also other specified requirements in section 28.4 of Regulation 552 depending on the nature of the service for which funding is requested.

Funding requirements for non-emergency laboratory tests performed outside Canada are described in section 28.5 of Regulation 552 of the *Health Insurance Act*.

There is no formal prior approval process required for services provided to eligible Ontario residents outside the province, but within Canada, if the insured service is covered under the Reciprocal Hospital Billing Agreements.

5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

All insured hospital, physician and surgical-dental services are available to Ontario residents on uniform terms and conditions.

All insured persons are entitled to all insured physician, surgical-dental and hospital services, as defined in the *Health Insurance Act* and regulations.

Access to insured services is protected under Part II of the *Commitment to the Future of Medicare Act* (CFMA), "Health Services Accessibility." The Act prohibits any person or any entity from charging or accepting payment or other benefit for an insured service rendered to an insured person except as permitted in the Act. In addition, the CFMA prohibits physicians, practitioners and hospitals from refusing to

provide an insured service if an insured person chooses not to pay a "block fee" for an uninsured service. The Act further prohibits any person or entity from paying, conferring, or charging or accepting a payment or other benefit in exchange for preferred access for an insured person to an insured service.

The Ministry of Health and Long-Term Care (MOHLTC) investigates all possible contraventions of Part II of the CFMA that come to its attention. For situations in which it is found that a patient has been extra-billed, the Ministry ensures that the amount is repaid to that patient.

MOHLTC implemented Health Card Validation (HCV) to assist health care providers with access to information requested for Ontario Health Insurance Plan (OHIP) and claims payment. HCV allows the provider to determine the point-in-time status of a patient's Ontario health number (and version code) indicating eligibility or ineligibility for provincially-funded health care services, thereby reducing claim rejects. A health care provider may subscribe for validation services if they have a valid and active billing number as assigned by the Ministry. If patients require access to insured services and do not have a current health card in their possession, upon obtaining patient consent, the provider may obtain the necessary information by utilizing the accelerated health number release service provided by ServiceOntario's Health Number Look Up service which is offered 24 hours a day, 365 days per year to registered physicians.

The *Public Hospitals Act* prohibits public hospitals in Ontario from refusing to admit a patient if, by refusal of admission, the patient's life would be endangered.

Acute care priority services are designated, highly specialized, hospital-based services that deal with life-threatening conditions such as organ transplants, cancer surgery and treatments, and neuroservices. These services are often high-cost and are rapidly growing, which has made access a concern. Generally, these services are managed provincially, on a time-limited basis. Acute care priority services include:

- selected cardiovascular services;
- selected cancer services;
- chronic kidney disease services;
- critical care services; and
- organ and tissue donation and organ transplantation.

Primary Health Care: During 2011–2012, Ontario continued to align its new and existing primary health care delivery models to help improve and expand access to primary health care physician services for all Ontarians. The various primary health care physician compensation models encourage access to comprehensive primary health care services for Ontario as a whole, as well as for targeted population groups and remote under-serviced communities.

Health Care Connect (HCC): HCC helps Ontarians who are without a family health care provider (family doctor or nurse practitioner) to find one. People without a family health care provider are referred to a family doctor or a nurse practitioner who is accepting new patients in their community.

During 2011–2012, MOHLTC continued to administer various initiatives in order to improve access to health care services across the province. Ontario has taken initiatives to increase physician supply according to evidence-based needs, and enhance the retention and distribution of physicians in the province by such measures as:

- working with the Ministry of Training, Colleges and Universities to increase enrolment in medical schools for undergraduate spaces;
- expanding postgraduate positions for both family medicine and Royal College specialty positions;
- increasing rural and remote clinical education opportunities for medical students;
- supporting the Northern Ontario School for Medicine;
- supporting training and assessment programs for International Medical Graduates and other qualified physicians who do not meet certain requirements for practice in Ontario; and
- Supporting the HealthForceOntario Marketing and Recruitment Agency to help recruit and retain health care professionals in Ontario communities that need them.

Two initiatives to improve access across Ontario, including rural and northern communities, are the HealthForceOntario Northern and Rural Recruitment and Retention (NRRR) Initiative and the Northern Health Travel Grant (NHTG) Program.

- HealthForceOntario Northern and Rural Recruitment and Retention Initiative: The NRRR Initiative (launched April 2010) supports the recruitment and retention of physicians in rural and northern communities. The NRRR Initiative provides financial recruitment incentives to physicians and new physician graduates to set up new practices in a northern or highly rural community with a Rurality Index for Ontario score of 40 or more, or in one of the five major northern urban referral centers (Thunder Bay, Sudbury, North Bay, Sault Ste. Marie and Timmins).

- Northern Health Travel Grant Program: The NHTG Program helps defray travel-related costs for residents of Northern Ontario who must travel long distances to access OHIP insured services that are not locally available, within a radius of 100km. The travel grants are designed to ensure access to medical specialist services, or procedures performed at designated health care facilities. The NHTG Program also promotes using specialist services located in northern Ontario, which encourages more specialists to practice and remain in the north.

5.2 Physician Compensation and Dental-Surgical Services

Physicians are paid for the services they provide through a number of mechanisms. Some physician payments are provided through fee-for-service arrangements. Remuneration is based on the Schedule of Benefits under the *Health Insurance Act*. Other physician payment models include Primary Health Care Models (such as blended capitation models), Alternate Payment Plans, and new funding arrangements for physicians in Academic Health Science Centres.

In 2011–2012, 97% of General Practitioners received fee-for-service payments from OHIP, but less than 30% of them were paid solely on a fee-for-service basis. The remaining family physicians in Ontario receive funding through one of the primary health models: Comprehensive Care Models (CCM), Family Health Group (FHG), Family Health Network (FHN), Family Health Organization (FHO), Community Health Centres (CHC), Rural and Northern Physician Group Agreement (RNPGA), Group Health Centre (GHC), Blended Salary Model (BSM), and specialized agreements. Family Health Teams (FHTs) build upon existing primary health care physician funded models by providing funding for inter-disciplinary teams of providers such as nurse practitioners, nurses, social workers and dietitians. FHTs are located across Ontario, in both urban and rural settings, ranging in size, structure, scope and governance. Physicians participating in FHTs are funded by one of three compensation options that include: Blended Capitation (such as FHN or FHO), Complement Based Models (RNPGA or other specialized agreements) and BSM (for community-sponsored FHTs).

MOHLTC negotiates physician funding with the Ontario Medical Association (OMA). The last four-year Physician Services Agreement expired on March 31, 2012. Its focus was on access to family health care and reducing congestion in emergency departments. The Agreement provided a 3% one time payment to physicians in the first year of the Agreement and targeted increases to the Schedule of Benefits of 5% in the second year, 3% in the third year and 4.25% in the fourth year. Funding was also provided to support stabilizing physician human resources and government priorities, such as mental health, and to reward physicians groups that worked in collaboration with other service providers.

With respect to insured surgical-dental services, MOHLTC negotiates changes to the Schedule of Benefits for Dental Services with the Ontario Dental Association. In 2002–2003, MOHLTC and the Ontario Dental Association agreed on a multi-year funding agreement for dental services, which became effective on April 1, 2003, and continues to be in effect.

5.3 Payments to Hospitals

The Ontario budget system is a prospective reimbursement system that reflects the effects of workload increases, costs related to provincial priority services, wait time strategies, and cost increases in respect of above-average growth in the volume of service in specific geographic locations. Payments are made to hospitals on a semi-monthly basis.

Beginning April 1, 2012, Ontario will be moving to a Patient-Based Funding system for funding hospitals. Patient-Based Funding (PBF) will shift health care funding from the current predominately global budget system towards an activity-based funding model which ensures that patients get the right care, at the right place, at the right time and at the right price. PBF offers an integrated approach to health system funding and puts the patient at the forefront of all health care decisions through bundling payments to health service providers and adopting a 'money follows the patient' principle. PBF will expand on the Ontario Wait Time Strategy funding approach to link the majority of hospitals' funding to the types, volumes and quality of care they provide. PBF is a significant shift from the way Ontario hospitals are currently funded, still largely based on historically-derived global budgets established in 1969.

PBF is comprised of two key components: Health Based Allocation Model (HBAM) and Quality-Based Procedures (QBP) funding, which will together comprise 70% of the Health Service Provider's (HSP) total funding by the end of a three-year implementation period.

- Organizational-Level funding: allocated to HSPs as determined by characteristics of the population being served. A specific model, HBAM, is used to allocate funding in the hospital and community care access centre sectors; this allocation neither creates nor reduces overall funding but is a mechanism to spread the funding envelope.
- Quality-Based Procedures: specific patient groups that will allow the health system to achieve better quality and system efficiencies through utilizing a 'price x volume' approach. The price for each patient group will be grounded on evidence-informed practices and agreed-upon patient clinical pathways developed by clinical and administrative leadership.

- Global budgets will continue to be used for activities that cannot be modeled or that are unique, such as out-patient service costs.

QBPs are an integral part of PBF. QBPs are specific groups of patient services that present opportunities for HSPs to share clinical, evidence-informed best practices that will allow the health care system to achieve even better quality and efficiencies. QBPs use an evidence-informed approach to targeted clinical groups at the provincial level. QBP prices are structured and priced appropriately both to provide incentive and adequately reimburse providers for delivering high quality care.

QBPs have been identified using an evidence-based framework that offers four perspectives for identifying opportunity areas that have the potential for reducing variation, improving outcomes, safety, efficiency and/or patient centeredness. All four quadrants of the framework are quality-driven and reinforce the importance of the alignment between quality and funding.

The implementation of PBF will be a critical enabler for health system transformation; it is aimed to respond to the needs of patients and populations, be an incentive to improving quality, efficiency and integration, and to support the system transformation agenda of *The Excellent Care for All Act* (ECFAA). ECFAA and PBF implementation will combine activity-based funding with global funding to create a system that promotes access, quality and efficiency, and establishes payment levers to advance policy and system objectives while still ensuring overall cost containment. PBF implementation is a critical structural reform for reducing health spending growth from current 6%–7% annual increases to 3.1% by 2012–2013.

Internationally, PBF models have been implemented since 1983. Although Ontario is one of the last leading jurisdictions to move down this path. This puts the province in a unique position to learn from international best practices and lessons learned by others to create a funding model that is best suited for Ontario.

PBF promotes care in the most appropriate setting for a patient/client/resident's level of acuity and links providers' funding to services delivered to ensure that appropriate service levels are provided and access is maintained. PBF supports system capacity planning and quality improvement through directly linking funding to patient outcomes. The Ontario government's Excellent Care for All Strategy represents a significant culture shift in the province's health care system and a change in the province's approach to health care funding through a quality agenda. The funding approach will create a financial environment that supports the business case for providers to invest in quality improvement; to provide funding that reflects the quality of care that providers deliver; and to promote evidence-based practice. PBF has been identified as an important mechanism to strengthen the link between the delivery of high quality care and fiscal sustainability and plays a key role in advancing the government's quality agenda and its *Action Plan for Health Care*.

When they assumed responsibility for their local health care systems, Local Health Integration Networks (LHINs) negotiated two-year Hospital Service Accountability Agreements (H-SAAs) with hospitals and became the lead for the Hospital Annual Planning Submissions, which are the precursors to the H-SAAs. While the vision is for three-year agreements, the fiscal reality is that funding projections for three years are unrealistic. As such, the two-year 2008–2010 H-SAA will be amended for another term to cover 2012–2013, with updates to comply with legislative and policy changes. Once signed, the 2012–2013 Amending Agreement will be effective from April 1, 2012 through March 31, 2013.

Public hospitals submit planning submissions to the LHINs that are the result of broad consultations within the facilities (e.g., all levels of staff, unions, physicians and board), the community and region. Some of the data submitted in the planning submissions are used to populate schedules for service volumes and performance targets that form the contractual basis for the H-SAA.

The H-SAA outlines the terms and conditions of the services provided by the hospital, the funding it will receive, the performance expected, and service levels. There are various performance indicators that are monitored, managed and evaluated in the agreement. These performance indicators strive to describe:

- person experience (e.g.,emergency room length of stay);
- organizational health (e.g., current ratio [consolidated], total margin [consolidated]); and
- patient access and outcomes (e.g., global volumes, i.e., target volumes expected for rehabilitation, complex continuing care, mental health, total acute care, wait time volumes for MRI, CT, cataract surgery, hip and knee surgery, and selected cardiac services).

Indicators have a performance standard and target that are designed to encourage the hospital to move in a particular direction within the sector. The targets and performance corridors are negotiated yearly while taking into consideration the overall performance and contribution of the hospital to the larger system. Where particular indicators are outside of the performance corridor and present a risk, there are a number of options available to the LHIN. The hospital and LHIN may develop a Performance Improvement Plan to get the hospital back on track to achieving its targets.

Payments to hospitals have traditionally been based on historical global allocations and multi-year incremental increases that incorporate population growth and anticipated service demands within the available provincial

budget. The Ministry began implementation of the Health System Funding Reform (HSFR) in 2012–2013. Over the fiscal years 2012–2013 to 2014–2015, HSFR will shift much of Ontario's health care system funding for hospitals away from the current global funding allocation towards PBF, to further support quality, efficiency and effectiveness in the health care system.

The Interprovincial Hospital Reciprocal Billing Agreements are a convenient administrative arrangement in which provincial/territorial governments reimburse hospitals in their jurisdictions for insured services provided to patients from other provinces/territories.

MOHLTC reviews chronic care co-payment regulations and rates annually, accounting for changes in the Consumer Price Index and Old Age Security, and determines whether revisions to the regulations and rates are appropriate.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

The Government of Ontario publicly acknowledged the federal contributions provided through the Canada Health Transfer in its 2011–2012 publications.

REGISTERED PERSONS					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
1. Number as of March 31st (#).	12,700,000 [2]	12,800,000 [2]	12,900,000 [2]	13,100,000 [2]	13,212,728 [2]

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
Public Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
2. Number (#).	150 [3]	149 [3]	149 [3]	149 [3]	147 [3]
3. Payments for insured health services ($).	13,600,000,000 [4]	14,200,000,000 [4]	14,800,000,000 [4]	15,527,899,500 [4]	16,173,889,100 [4]
Private For-Profit Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
4. Number of private for-profit facilities providing insured health services (#).	not available [5]	not available [5]	not available [5]	not available [5]	not available [5]
5. Payments to private for-profit facilities for insured health services ($).	not available [5]	not available [5]	not available [5]	not available [5]	not available [5]

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
6. Total number of claims, in-patient (#).	7,130	9,457	8,185	8,231	6,365
7. Total payments, in-patient ($).	45,712,000	65,183,888	64,688,077	68,384,505	46,960,837
8. Total number of claims, out-patient (#).	166,373	161,193	138,594	130,855	116,541
9. Total payments, out-patient ($).	31,052,000	38,030,901	36,399,952	35,431,819	33,598,383
INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA					
10. Total number of claims, in-patient (#).	24,327	21,869	28,223	28,420	30,348
11. Total payments, in-patient ($).	113,663,332	136,036,532	91,456,638	52,706,316	42,559,353
12. Total number of claims, out-patient (#).	not available [6]	not available [6]	not available [6]	not available [6]	not available [6]
13. Total payments, out-patient ($).	not available [7]	not available [7]	not available [7]	not available [7]	not available [7]

2. These estimates represent the number of Valid and Active Health Cards (have current eligibility and resident has incurred a claim in the last 7 years).
3. Number represents all publicly-funded hospitals excluding specialty psychiatric hospitals. Specialty psychiatric hospitals are excluded in order to conform to CHAAR reporting guide.
4. Amount represents funding for all public hospitals excluding specialty psychiatric hospitals.
5. Data are not collected in a single system in MOHLTC. Further, the MOHLTC is unable to categorize providers/facilities as "for-profit" as MOHLTC does not have financial statements detailing service providers' disbursement of revenues from the Ministry.
6. Included in #10.
7. Included in #11.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
14. Number of participating physicians (#).	23,859	24,411	25,166	25,995	26,818
15. Number of opted-out physicians (#).	40	39	35	34	32
16. Number of non-participating physicians (#).	0 [8]	0 [8]	0 [8]	0 [8]	0 [8]
17. Total payments for services provided by physicians paid through all payment methods ($).	8,410,478,000 [9]	9,324,794,000 [9]	10,033,761,000 [9]	9,070,713,617 [9]	11,332,919,800 [9]
18. Total payments for services provided by physicians paid through fee-for-service ($).	5,962,775,787	6,528,353,572	6,812,333,798	7,052,261,365	7,508,636,523

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
19. Number of services (#).	759,570	683,377	596,430	723,766	536,447
20. Total payments ($).	25,180,900	26,471,536	26,204,597	25,237,480	25,252,852
INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA					
21. Number of services (#).	211,323	247,741	216,715	213,717	234,420
22. Total payments ($).	37,901,297	54,780,594	41,652,064	12,455,597	7,922,281

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2v007–2008	2008–2009	2009–2010	2010–2011	2011–2012
23. Number of participating dentists (#).	317	291	277	282	262
24. Number of services provided (#).	91,540	99,212	99,427	96,797	96,735
25. Total payments ($).	13,423,384	13,916,464	14,324,505	13,525,890	13,532,519

8. Ontario has no non-participating physicians, only opted-out physicians who are reported under item #15.
9. Total Payments includes payments made to Ontario physicians through Fee-for-Service, Primary Care, Alternate Payment Programs, and Academic Health Science Centres and the Hospital On Call Program. Services and payments related to Other Practitioner Programs, Out-of-Country/Out-of-Province Programs, and Community Labs are excluded.
   — Fiscal Year 2009–2010 has been updated to agree with Public Accounts.
   — Fiscal Year 2010–2011 has been updated to agree with Public Accounts.
   — Fiscal Year 2011–2012 is based on Interim (Unpublished) Public Accounts.

MANITOBA

INTRODUCTION

Manitoba Health provides leadership and support to protect, promote and preserve the health of all Manitobans. The roles and responsibilities of the Department include policy, program and standards development, fiscal and program accountability, and evaluation. In addition, specific direct services continue to be provided through Selkirk Mental Health Centre, Cadham Provincial Laboratory, public health inspections, and provincial nursing stations, etc.

Manitoba Health remains committed to the principles of Medicare and improving the health status of all Manitobans. In support of these commitments, highlights of activities initiated in 2011–2012 included:

- Launched the Cancer Wait Time Strategy, "Transforming the Cancer Patient Journey in Manitoba."
- Continued to support initiatives, such as *A Family Doctor for Every Manitoban by 2015*.
- Increased number of physicians in Manitoba, demonstrating continued improvement in their recruitment and retention.
- Supported medical enrolment and rural medical studies and kept medical school tuitions affordable.
- Improved services, gender-based research and policies and increased awareness about women's health issues through *The Women's Health Strategy*.
- Stakeholder training in area-specific quality improvement methodology (i.e. Lean Six Sigma, Advanced Access and Releasing Time to Care).
- Completed construction of two renal health dialysis units in Hodgson, the Western Manitoba Cancer Centre, a Bilingual Service Centre, the South Winnipeg Birth Centre, and redevelopment of Victoria General Hospital's Emergency and Out-patient departments.

1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

The Manitoba Health Services Insurance Plan (MHSIP) is administered by Manitoba Health under the *Health Services Insurance Act*, R.S.M. 1987, c. H35.

The MHSIP is administered under this Act for insurance in respect of the costs of hospital, personal care, and medical and other health services referred to in acts of the Legislature or regulations thereunder.

The Minister of Health is responsible for administering and operating the Plan. The Minister may also enter into contracts and agreements with any person or group that he or she considers necessary for the purposes of the Act.

The Minister may also make grants to any person or group for the purposes of the Act on such terms and conditions that are considered advisable. Also, the Minister may, in writing, delegate to any person any power, authority, duty or function conferred or imposed upon the Minister under the Act or under the regulations.

There were no legislative amendments to the Act or the regulations in the 2011–2012 fiscal year that affected the public administration of the Plan.

1.2 Reporting Relationship

Section 6 of the *Health Services Insurance Act* requires the Minister to have audited financial statements of the Plan showing separately the expenditures for hospital services, medical services and other health services. The Minister is required to prepare an annual report, which must include the audited financial statements, and to table the report before the Legislative Assembly within 15 days of receiving it, if the Assembly is in session. If the Assembly is not in session, the report must be tabled within 15 days of the beginning of the next session.

1.3 Audit of Accounts

Section 7 of the *Health Services Insurance Act* requires that the Office of the Auditor General of Manitoba (or another auditor designated by the Office of the Auditor General of Manitoba) audit the accounts of the Plan annually and prepare a report on that audit for the Minister. The most recent audit reported to the Minister and available to the public is for the 2011–2012 fiscal year and is contained in the Manitoba Health Annual Report, 2011–2012. It is available at http://www.gov.mb.ca/health/ann/index.html.

2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

Sections 46 and 47 of the *Health Services Insurance Act*, as well as the Hospital Services Insurance and Administration Regulation (M.R. 48/93), provide for insured hospital services.

As of March 31, 2012, there were 96 facilities providing insured hospital services to both in- and out-patients. Hospitals are designated by the Hospitals Designation Regulation (M.R. 47/93) under the Act.

Services specified by the Regulation as insured in- and out-patient hospital services include: accommodation and meals at the standard ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures; drugs, biologics and related preparations; routine medical and surgical supplies; use of operating room, case room and anaesthetic facilities; and use of radiotherapy, physiotherapy, occupational and speech therapy facilities, where available.

All hospital services are added to the list of available hospital services through the health planning process. Manitoba residents maintain high expectations for quality health care and insist that the best available medical knowledge and service be applied to their personal health situations. Manitoba Health is sensitive to new developments in the health sciences.

2.2 Insured Physician Services

The enabling legislation that provides for insured physician services is the Medical Services Insurance Regulation (M.R. 49/93) made under the *Health Services Insurance Act*.

Physicians providing insured services in Manitoba must be lawfully entitled to practice medicine in Manitoba, and be registered and licensed under the *Medical Act*. As of March 31, 2012, there were 2,552 registered in Manitoba.

A physician, by giving notice to the Minister in writing, may elect to collect the fees for medical services rendered to insured persons other than from the Minister, in accordance with section 91 of the Act and section 5 of the Medical Services Insurance Regulation. The election to opt out of the health insurance plan takes effect on the first day of the month following a 90-day period from the date the Minister receives the notice.

Before rendering a medical service to an insured person, physicians must give the patient reasonable notice that they propose to collect any fee for the medical service from them or any other person except the Minister. The physician is responsible for submitting a claim to the Minister on the patient's behalf and cannot collect fees in excess of the benefits payable for the service under the Act or regulations. No physicians opted out of the medical plan in 2011–2012.

The range of physician services insured by Manitoba Health is listed in the Payment for Insured Medical Services Regulation (M.R. 95/96). Coverage is provided for all medically required personal health care services that are not excluded under the Excluded Services Regulation (M.R. 46/93) of the Act, rendered to an insured person by a physician.

During fiscal year 2011–2012, a number of new insured services were added to a revised fee schedule. The Physician's Manual can be viewed on-line at: http://www.gov.mb.ca/health/manual/index.html.

In order for a medical service to be added to the list of those covered by Manitoba Health, physicians must put forward a proposal to their specific section of Doctors Manitoba (DMb). The DMb will negotiate the item, including the fee, with Manitoba Health. Manitoba Health may also initiate this process.

2.3 Insured Surgical-Dental Services

Insured surgical and dental services are listed in the Hospital Services Insurance and Administration Regulation (M.R. 48/93) under the *Health Services Insurance Act*. Surgical services are insured when performed by a certified oral and maxillofacial surgeon or a licensed dentist in a hospital, when hospitalization is required for the proper performance of the procedure. This Regulation also provides benefits relating to the cost of insured orthodontic services in cases of cleft lip and/or palate for persons registered under the program by their 18th birthday, when provided by a registered orthodontist.

Providers of dental services may elect to collect their fees directly from the patient in the same manner as physicians and may not charge to or collect from an insured person a fee in excess of the benefits payable under the Act or regulations. No providers of dental services had opted out in 2011–2012.

In order for a dental service to be added to the list of insured services, a dentist must put forward a proposal to the Manitoba Dental Association (MDA). The MDA negotiates the item and fee with Manitoba Health.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

The Excluded Services Regulation (M.R. 46/93) made under the *Health Services Insurance Act* sets out those services that are not insured. These include: examinations and reports for reasons of employment, insurance, attendance at university or camp, or performed at the request of third

parties; group immunization or other group services except where authorized by Manitoba Health; services provided by a physician, dentist, chiropractor or optometrist to him or herself or any dependants; preparation of records, reports, certificates, communications and testimony in court; mileage or travelling time; services provided by psychologists, chiropodists and other practitioners not provided for in the legislation; in vitro fertilization; tattoo removal; contact lens fitting; reversal of sterilization procedures; and psychoanalysis.

The Hospital Services Insurance and Administration Regulation states that hospital in-patient services include routine medical and surgical supplies, thereby ensuring reasonable access for all residents. The regional health authorities and Manitoba Health monitor compliance.

All Manitoba residents have equal access to services. Third parties such as private insurers or the Workers Compensation Board do not receive priority access to services through additional payment. Manitoba has no formalized process to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows regional health authorities and Manitoba Health to monitor usage and service concerns.

To de-insure services covered by Manitoba Health, the Ministry prepares a submission for approval by Cabinet. The need for public consultation is determined on an individual basis depending on the subject.

No services were removed from the list of those insured by Manitoba Health in 2011–2012.

3.0 UNIVERSALITY

3.1 Eligibility

The *Health Services Insurance Act* defines the eligibility of Manitoba residents for coverage under the provincial health care insurance plan. Section 2(1) of the Act states that a resident is a person who is legally entitled to be in Canada, makes his or her home in Manitoba, is physically present in Manitoba for at least six months in a calendar year, and includes any other person classified as a resident in the regulations, but does not include a person who holds a temporary resident permit under the *Immigration and Refugee Protection Act* (Canada), unless the Minister determines otherwise, or is a visitor, transient or tourist.

The Residency and Registration Regulation (M.R. 54/93) extends the definition of residency. The extensions are found in sections 7(1) and 8(1). Section 7(1) allows missionaries, individuals with out-of-country employment and individuals undertaking sabbatical leave to be outside Manitoba for up to two years while still remaining residents of Manitoba. Students are deemed to be Manitoba residents while in full-time attendance at an accredited educational institution. Section 8(1) extends residency to individuals who are legally entitled to work in Manitoba and have a work permit of 12 months or more and to individuals who hold study permits of 6 months or more under the *Immigration and Refugee Protection Act* (Canada).

The Residency and Registration Regulation, section 6, defines Manitoba's waiting period as follows:

> "A resident who was a resident of another Canadian province or territory immediately before his or her arrival in Manitoba is not entitled to benefits until the first day of the third month following the month of arrival."

There are currently no other waiting periods in Manitoba.

The Manitoba Health Services Insurance Plan (MHSIP) excludes residents covered under any federal plan, including the following federal statutes: *Aeronautics Act*; *Civilian War-related Benefits Act*; *Government Employees Compensation Act*; *Merchant Seaman Compensation Act*; *National Defence Act*; *Pension Act*; *Veteran's Rehabilitation Act*; federal inmates or those covered under legislation of any other jurisdiction (Excluded Services Regulations subsection 2(2)). These residents become eligible for Manitoba Health coverage upon discharge from the Canadian Forces, or in the case of an inmate of a penitentiary, upon discharge if the inmate has no resident dependants. Upon change of status, these persons have one month to register with Manitoba Health (Residency and Registration Regulation (M.R. 54/93, subsection 2(3)).

The process of issuing health insurance cards requires that individuals inform and provide documentation to Manitoba Health that they are legally entitled to be in Canada, and that they intend to be physically present in Manitoba for six months in a calendar year. They must also provide a primary residence address in Manitoba. Upon receiving this information, Manitoba Health will provide a registration card for the individual and all qualifying dependants.

Manitoba has two health-related numbers. The registration number is a six-digit number assigned to an individual 18 years of age or older who is not classified as a dependant. This number is used by Manitoba Health to pay for all medical service claims for that individual and all designated dependants. A nine-digit Personal Health Identification Number (PHIN) is used for payment of all hospital services and for the provincial drug program.

As of March 31, 2012, there were 1,265,059 residents registered with the Manitoba Health Services Insurance Plan.

There is no provision for a resident to opt out of the Manitoba Health Plan.

3.2 Other Categories of Individual

The Residency and Registration Regulation (M.R. 54/93, sub-section 8(1)) requires that temporary workers possess a work permit issued by Citizenship and Immigration Canada for at least 12 consecutive months, be physically present in Manitoba for six months in a calendar year, and be legally entitled to be in Canada before receiving Manitoba Health coverage. As of March 31, 2012, there were 5,275 individuals on work permits and 589 individuals on study permits covered under the MHSIP. The definition of "resident" under the *Health Services Insurance Act* allows the Minister of Health or the Minister's designated representative to provide coverage for holders of a Minister's permit under the *Immigration and Refugee Protection Act* (Canada). No legislative amendments to the Act or the regulations in the 2011–2012 fiscal year affected universality.

4.0 PORTABILITY

4.1 Minimum Waiting Period

The Residency and Registration Regulation (M.R. 54/93, section 6) identifies the waiting period for insured persons from another province or territory. A resident who lived in another Canadian province or territory immediately before arriving in Manitoba is entitled to benefits on the first day of the third month following the month of arrival.

4.2 Coverage During Temporary Absences in Canada

The Residency and Registration Regulation (M.R. 54/93 section 7(1)) defines the rules for portability of health insurance during temporary absences in Canada.

Students are considered residents and will continue to receive health coverage for the duration of their full-time enrolment at any accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba after completing their studies. Manitoba has formal agreements with all Canadian provinces and territories for the reciprocal billing of insured hospital services. Manitoba has a bilateral agreement with the Province of Saskatchewan for Saskatchewan residents who receive care in Manitoba border communities.

In-patient costs are paid at standard rates approved by the host province or territory. Payments for in-patient, high-cost procedures and out-patient services are based on national rates agreed to by provincial and territorial health plans. These include all medically necessary services as well as costs for emergency care.

Except for Quebec, medical services incurred in all provinces or territories are paid through a reciprocal billing agreement at host province or territory rates. Claims for medical services received in Quebec are submitted by the patient or physician to Manitoba Health for payment at host province rates.

4.3 Coverage During Temporary Absences Outside Canada

The Residency and Registration Regulation (M.R. 54/93, sub-section 7(1)) defines the rules for portability of health insurance during temporary absences from Canada.

Residents on full-time employment contracts outside Canada will receive Manitoba Health coverage for up to 24 consecutive months. Individuals must return and reside in Manitoba after completing their employment terms. Clergy serving as humanitarian aid workers or missionaries on behalf of a religious organization approved as a registered charity under the *Income Tax Act* (Canada) will be covered by Manitoba Health for up to 24 consecutive months. Students are considered residents and will continue to receive health coverage for the duration of their full-time enrollment at an accredited educational institution. The additional requirement is that they intend to return and reside in Manitoba after completing their studies. Residents on sabbatical or educational leave from employment will be covered by Manitoba Health for up to 24 consecutive months. These individuals also must return and reside in Manitoba after completing their leave.

Coverage for all these categories is subject to amounts detailed in the Hospital Services Insurance and Administration Regulation (M.R. 48/93). Hospital services received outside Canada due to an emergency or a sudden illness, while temporarily absent, are paid as follows:

In-patient services are paid based on a per-diem rate according to hospital size:

- 1–100 beds: $280
- 101–500 beds: $365
- over 500 beds: $570

Out-patient services are paid at a flat rate of $100 per visit or $215 for haemodialysis.

The calculation of these rates is complex due to the diversity of hospitals in both rural and urban areas.

Physician services received in the United States are paid at the equivalent Manitoba rate for similar services.

Manitobans requiring medically necessary hospital services unavailable in Manitoba or elsewhere in Canada may be eligible for costs incurred in the United States by providing Manitoba Health with a recommendation from a specialist stating that the patient requires a specific, medically necessary service. In cases where a patient is referred out of country, and receives the prior approval of Manitoba Health, hospital services are paid at a minimum of 75 percent of the hospital's charges for insured services. Payment for hospital services is made in U.S. funds (the Hospital Services Insurance and Administration Regulation, sections 15-23). In instances where Manitoba Health has given prior approval for services provided outside Canada, Manitoba Health will consider additional funding based on financial need.

4.4 Prior Approval Requirement

Prior approval is not required for procedures that are covered under the interprovincial reciprocal agreements with other provinces. Prior approval by Manitoba Health is required for high cost items or procedures that are not included in the reciprocal agreements.

All non-emergency hospital and medical care provided outside Canada require prior approval from Manitoba Health.

5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

Manitoba Health ensures that medical services are equitable and reasonably available to all Manitobans. Effective January 1, 1999, the Surgical Facilities Regulation (M.R. 222/98) under the *Health Services Insurance Act* came into force to prevent private surgical facilities from charging additional fees for insured medical services.

In July 2001, the *Health Services Insurance Act*, the *Private Hospitals Act* and the *Hospitals Act* were amended to strengthen and protect public access to the health care system. The amendments include:

- changes to definitions and other provisions to ensure that no charges can be made to individuals who receive insured surgical services or to anyone else on that person's behalf; and
- ensuring that a surgical facility cannot perform procedures requiring overnight stays and thereby function as a private hospital.

Manitoba Health continues to invest in improving clients' access. In 2010, Manitoba made a commitment that all Manitobans will have access to a family physician by 2015. To achieve this goal, Manitoba invested in new initiatives such as Primary Care Networks (including teams), opened three Quick Care Clinics, mobile Primary Care in communities across the province, and introduced more opportunities and supports for Manitobans to self-manage their health care. Investment also continued in existing initiatives that enhance capacity, quality and efficiency in primary care, such as the Physician Integrated Network, TeleCARE Manitoba (a chronic disease self-management resource for congestive heart failure and diabetes), and an After-Hours Call Community Network pilot (a network of general practitioners linked to patients through the 24-hour Health Links-Info Santé service). Since 2008, Manitoba Health funded and coordinated over 30 primary and specialty clinics to successfully complete the Advanced Access training, enabling them to offer patients same-day access to a primary care provider and five-day access to a specialist. The Winnipeg Birth Centre opened in October 2011. In addition to providing an alternative option to support low risk childbirth outside of a hospital or home, the Birth Centre offers various maternal and child health programs.

All Manitobans have access to hospital services including acute care, psychiatric extended treatment, mental health, palliative, chronic, long-term assessment/rehabilitation, and to personal care facilities. There has been a shift in focus from hospital beds to community services, out-patients and day surgeries, which are also insured services.

The Western Manitoba Cancer Centre (WMCC) opened in June 2011 and is located at the Brandon Regional Health Centre (BRHC). This $24 million state-of-the-art facility is the first location outside of Winnipeg to provide radiation therapy and increases the overall capacity for cancer services within the province. In addition to radiation therapy, the WMCC provides a broad range of cancer treatment and support services including:

- chemotherapy;
- a simulation suite with a CT scanner for treatment planning;
- advanced information and communication technologies that will transmit data and pictures between the WMCC and CancerCare Manitoba (CCMB) in Winnipeg, allowing staff at both locations to interact around detection, surveillance and treatment options;
- out-patient care services;
- supportive care areas, including a quiet care and comfort area for patients and family to relax; and
- a staff area with a lunch room, showers, washroom, locker areas, resource area with computer access and reference material.

In June 2011, Manitoba announced the implementation of the first-in-Canada, Cancer Wait Time Strategy entitled "Transforming the Cancer Patients' Journey in Manitoba." This $40 million comprehensive and aggressive strategy

will streamline cancer services and dramatically reduce the wait time for patients between the time cancer is suspected and the start of effective treatment to two months or less. As part of this initiative, in December 2011, Manitoba's first regional CancerCare hub was announced in Morden-Winkler. The CancerCare hub expands on the chemotherapy services currently available through the community cancer programs and is the first of many to provide world-class cancer care no matter where you live by co-ordinating access to expanded services like cancer screening and early detection services, cancer risk-reduction programs and palliative care.

Manitobans access to renal health dialysis services increased through the addition of ten dialysis stations at the Winnipeg Health Sciences Centre site and the opening of two new renal health dialysis units each containing four dialysis stations (one is located at the Gimli Community Health Centre to serve residents of the Interlake communities and the second is located in the Russell District Health Centre to serve residents in communities central western Manitoba). The launch of a pilot renal health clinic Telehealth project located in a northern Manitoba community aimed to increase access to support services for people living with chronic kidney disease in the surrounding area.

In the Provincial Nursing Stations, measures were taken to support access to primary health care professionals and specialists through programming such as MBTeleheath, on-going staff training, and increased communications with local and regional health authorities. Acute and emergency care has been enhanced by increasing the drug formulary, acquisition of new equipment, and by staff recruitment and retention initiatives.

The MBTelehealth program continues to grow and currently has over 110 sites in Manitoba, including 24 sites in First Nation communities. In 2011–12 MBT total events reached over 16,000, of which approximately 76% were clinical services. Patients have access to over 200 specialists. Specialties include, but are not limited to, oncology, dermatology, renal health, and psychiatry. Other uses include continuing education, administrative meetings and televisitation. Provider and patient response to the program continues to be very positive and demand for new sites continues to be high.

In acute care and diagnostic services, initiatives such as Releasing Time to Care and Lean Six Sigma were implemented to improve patient flow and patient access, along with wait list management activities and enhanced service funding to reduce backlogs. Throughout 2011–2012, the Patient Access Registry Tool, an electronic booking request and wait-time/wait list management system, was implemented throughout the Winnipeg Regional Health Authority (WRHA) for adult elective surgery.

Funding to enhance volume of services has been sustained and increased. Manitoba continues to work with its regional health authority partners in exploring and implementing improved access models, and investigating demand management strategies, including improved appropriateness of services.

Manitoba Health continues to support the provision of accessible services in rural and northern regional health authorities, including the following projects and funding that were announced in 2011: a $42.4 million investment in reduced wait time for diagnostic testing, cardiac and orthopedic services, including investments at Brandon Regional Health Centre and Boundary Trails Health Centre in Morden-Winkler; a 45,000 square foot expansion of the Bethesda Hospital Emergency Department in Steinbach; a $14.1 million expansion and renovation of Ste. Anne Hospital; an $8.7 million investment in new diagnostic equipment, including a CT scanner for Bethesda Hospital, and a new bone densitometer at Brandon Regional Health Centre; and the introduction of dental surgery services at Swan Valley Health Centre in Swan River.

Manitoba continues to have growth in the number of active practicing nurses through expansions to the nursing education programs and strategies of the Nurses Recruitment and Retention Fund (NRRF). According to the registration data received from the Colleges of Registered Nurses, Registered Psychiatric Nurses and Licensed Practical Nurses, there were 17,265 active practicing nurses in Manitoba in 2011. This is a net gain of 147 more nurses than in 2010. There remain; however, ongoing nursing resource challenges in some rural and northern regions, and in specialty care areas in Winnipeg. Manitoba has increased nursing education seats throughout the province resulting in a more than doubling of enrolments in the last 10 years.

The NRRF also contributes significantly to improving the nursing supply in Manitoba through initiatives such as relocation assistance; the Conditional Grant Program, which encourages new graduates to work in rural and northern regions (outside Winnipeg and Brandon); the personal care home grant; and funding for continuing education and specialty education programs. The Extended Practice Regulation allows nurses on the register to independently prescribe drugs, order screening and diagnostic tests, and perform minor surgical and invasive procedures as set out in regulation. The number of nurses on the register has grown from 4 in June 2005 to 110 as of the December 31, 2011 registration year.

Manitoba Health has developed and provided funding for a number of initiatives to address shortages in various allied health professions. Examples include: increasing seats in the ultrasound training program, the medical laboratory technologist training program and the medical radiologic

technologist training program as well as reserving seats in training programs in other jurisdictions, such as the nuclear medicine technologist training program in Alberta and the prosthetics and orthotics training program in British Columbia. Along with reserving these seats students are expected to sign return of service agreements to return to Manitoba for employment post graduation for a specified period of time.

Manitoba continues to experience increases in the number of new physicians registering with the licensing body. Manitoba has increased the number of grants available to medical students, providing recipients with financial assistance in each of their four years of medical school. Each grant requires a commitment to return service to under-serviced populations upon graduation. There have been significant increases in the number of students accessing grants and agreeing to practice in under-serviced communities since improvements to the Program came into effect in the Fall of 2011. It is expected that increased Program enrollment to continue.

The Province also provides a provincial specialist fund and resettlement fund to practicing physicians who choose to move to underserviced areas of the Province. The Resettlement Fund is open to both family practitioners and specialists, and there has been significant take up of the program, with many physicians moving to rural and northern Manitoba.

In an effort to support the repatriation of Manitobans/Canadians studying abroad back to Manitoba, the Province has established a repatriation coordinator. The coordinator chairs a repatriation working group which aims to develop potential pathways for Manitoba medical students/residents to return to Manitoba for training and practice opportunities.

Through the current assessment and training programs, foreign-trained physicians can achieve conditional licensure to practice medicine in return for agreeing to work in a sponsoring rural regional health authority. Upon successful completion of the assessments, candidates may be recommended for conditional licensure and, upon commencement of practice, are linked with a physician mentor for a minimum of 12 months. The Province supports assessment training programs for foreign-trained family medicine and specialist physicians.

5.2 Physician Compensation

Manitoba continues to employ the following methods of payment for physicians: fee-for-service, contract, blended and sessional.

The *Health Services Insurance Act* governs remuneration to physicians for insured services. There were no amendments to the *Health Services Insurance Act* related to physician compensation during the 2011–12 fiscal year.

Fee-for-service remains the dominant method of payment for physician services. Notwithstanding, alternate payment arrangements constitute a significant portion of the total compensation to physicians in Manitoba. Alternate-funded physicians are those who receive non fee-for-service compensation, including through a salary (employment relationship) or those who work on an independent contract basis. Manitoba also uses blended payment methods to adjust fee-for-service income that may not be adequate to compensate for all services rendered by the physician. As well, physicians may receive sessional payments for providing medical services on a time based arrangement, as well as stipends for on-call and other responsibilities.

Manitoba Health represents Manitoba in negotiations with physicians. The physicians are typically represented by Doctors Manitoba with some notable exceptions, such as oncologists.

The current Master Agreement between Doctors Manitoba and Manitoba has an effective date from April 1, 2011 to March 31, 2015.

The Physician's Manual, a billing and fee guide, provides Manitoba physicians with a listing of medical services that are insured by Manitoba Health. Five main system data checks and processes within the Manitoba Health mainframe ensure that claims for insured services are processed in accordance with the Rules of Application in the Physician's Manual under the *Health Services Insurance Act*. Appeals under the Physician's Manual are heard by a grievance panel. In addition, the Manitoba Health Appeal Board, a quasi-judicial tribunal, hears appeals if a person is not satisfied with certain decisions of Manitoba Health or is denied entitlement to a benefit under the *Health Services Insurance Act*.

5.3 Payments to Hospitals

Division 3.1 of Part 4 of the *Regional Health Authorities Act* sets out the requirements for operational agreements between regional health authorities and the operators of hospitals and personal care homes, defined as "health corporations" under the Act.

Pursuant to the provisions of this division, regional health authorities are prohibited from providing funding to a health corporation for operational purposes unless the parties have entered into a written agreement for this purpose that enables the health services to be provided by the health corporation, the funding to be provided by the regional health authority for the health services, the term of the agreement, and a dispute

resolution process and remedies for breaches. If the parties cannot reach an agreement, the Act enables them to request that the Minister of Health appoint a mediator to help them resolve outstanding issues. If the mediation is unsuccessful, the Minister is empowered to resolve the matter or matters in dispute. The Minister's resolution is binding on the parties.

There are three regional health authorities which have hospitals operated by health corporations in their health regions. The regional health authorities have concluded the required agreements with health corporations. The operating agreements enable the regional health authority to determine funding based on objective evidence, best practices and criteria that are commonly applied to comparable facilities. In all other regions, the hospitals are operated by the *Regional Health Authorities Act*. Section 23 of the Act requires that regional health authorities allocate their resources in accordance with the approved regional health plan.

The allocation of resources by regional health authorities for providing hospital services is approved by Manitoba Health through the approval of the regional health authorities' regional health plans, which the regional health authorities are required to submit for approval pursuant to section 24 of the *Regional Health Authorities Act*. Section 23 of the Act requires that authorities allocate their resources in accordance with the approved regional health plan.

Pursuant to subsection 50(2.1) of the *Health Services Insurance Act*, payments from the Medical Health Services Insurance Plan for insured hospital services are to be paid to the regional health authorities. In relation to those hospitals that are not owned and operated by a regional health authority, the regional health authority is required to pay each hospital in accordance with any agreement reached between the regional health authority and the hospital operator.

No legislative amendments to the Act or the regulations in 2011–2012 had an effect on payments to hospitals.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

Manitoba routinely recognizes the federal role regarding the contributions provided under the Canada Health Transfer (CHT) in public documents. Federal transfers are identified in the Estimates of Expenditures and Revenue (Manitoba Budget) document and in the Public Accounts of Manitoba. Both documents are published annually by the Manitoba government. In addition, Manitoba Health cites the federal contribution from the First Ministers Ten Year Plan to Strengthen Health Care (the 2004 Health Accord—Wait Time Reduction Fund) in funding letters to the regional health authorities and other organizations which are implementing programs using this funding.

REGISTERED PERSONS					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
1. Number as of March 31st [#].	1,186,386	1,209,401	1,228,246	1,230,270	1,265,059

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
Public Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
2. Number [#].	97	97	96	96	96
3. Payments for insured health services [$].	not available	not available	not available	not available	not available
Private For-Profit Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
4. Number of private for-profit facilities providing insured health services [#].	1	1	1	1	1
5. Payments to private for-profit facilities for insured health services [$].	1,289,964	1,553,438	1,570,832	1,541,540	2,005,150

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
6. Total number of claims, in-patient [#].	2,823	3,280	2,626	2,844	2,899
7. Total payments, in-patient [$].	18,731,739	24,489,298	21,612,535	27,092,558	26,478,561
8. Total number of claims, out-patient [#].	31,329	35,957	28,729	30,983	29,070
9. Total payments, out-patient [$].	6,933,920	9,662,718	8,655,118	10,454,203	10,706,338
INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA					
10. Total number of claims, in-patient [#].	549	658	552	634	646
11. Total payments, in-patient [$].	1,791,864	3,252,651	1,924,044	2,454,364	1,913,457
12. Total number of claims, out-patient [#].	8,796	10,121	10,097	10,706	11,311
13. Total payments, out-patient [$].	2,692,096	2,650,500	2,954,321	3,022,630	3,226,581

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
14. Number of participating physicians (#).	2,050	2,073	2,121	2,276	2,322
15. Number of opted-out physicians (#).	0	0	0	0	0
16. Number of non-participating physicians (#).	not applicable	not applicable	not applicable	not applicable	not applicable
17. Total payments for services provided by physicians paid through all payment methods ($).	721,552,291	789,101,000	843,087,000	920,890,000	927,916,000
18. Total payments for services provided by physicians paid through fee-for-service ($).	459,573,573	476,227,782	552,890,200	553,924,806	595,083,828

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
19. Number of services (#).	290,775	243,881	237,192	267,122	231,683
20. Total payments ($).	9,985,987	9,721,570	10,287,990	9,909,927	10,989,977
INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA					
21. Number of services (#).	6,414	7,446	6,768	7,226	8,285
22. Total payments ($).	701,829	725,382	627,563	953,272	703,353

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
23. Number of participating dentists (#).	120	131	135	133	131
24. Number of services provided (#).	4,616	4,833	5,950	5,475	5,290
25. Total payments ($).	1,107,357	1,175,314	1,701,655	1,522,545	1,468,524

SASKATCHEWAN

INTRODUCTION

Through leadership and partnership, the Ministry of Health is committed to providing high-quality health care to the people of Saskatchewan through a responsive, efficient, and patient- and family-centered health care system. The Ministry's priority is a health system that puts patients and families first, and provides the best possible health care.

The health care system in Saskatchewan is multi-faceted and complex. To ensure the provision of essential and appropriate services, the Ministry establishes provincial strategy and policy direction, sets and monitors standards, and provides funding.

The Ministry also works in partnership with organizations at the local, regional, provincial, national and international levels to provide Saskatchewan residents with access to quality health care. The Ministry oversees a health care system that includes 12 regional health authorities (RHAs), the Saskatchewan Cancer Agency (SCA), the Athabasca Health Authority, affiliated health care organizations and a diverse group of professionals, many of whom are in private practice.

There are 26 self-regulated health professions in the province and the health system as a whole employs more than 40,000 people who provide a broad range of services. The Ministry supports the RHAs, SCA and other stakeholders to recruit and retain health care providers, including nurses and physicians. The Ministry is also responsible for approximately 50 different pieces of legislation.

The Ministry is organized into: Specialized Programs; Community and Primary Health; and Strategy and Performance Management. The Saskatchewan Surgical Initiative; Communications Branch; and the Provincial Kaizen Promotion office report directly to the Deputy Minister.

For more information about the Ministry's programs and services, please visit the Ministry of Health website at: www.health.gov.sk.ca

1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

The provincial government is responsible for funding and ensuring the provision of insured hospital, physician and surgical-dental services in Saskatchewan. Section 6.1 of *The Department of Health Act* authorizes that the Minister of Health may:

- pay part of, or the whole of, the cost of providing health services for any persons or classes of person who may be designated by the Lieutenant Governor-in-Council;
- make grants or loans, or provide subsidies to regional health authorities, health care organizations or municipalities for providing and operating health services or public health services;
- pay part of, or the whole of, the cost of providing health services in any health region or part of a health region in which those services are considered by the Minister to be required;
- make grants or provide subsidies to any health agency that the Minister considers necessary; and
- make grants or provide subsidies to stimulate and develop public health research, and to conduct surveys and studies in the area of public health.

Sections 8 and 9 of *The Saskatchewan Medical Care Insurance Act* provide the authority for the Minister of Health to establish and administer a plan of medical care insurance for residents. *The Regional Health Services Act* provides the authority to establish 12 regional health authorities, replacing the former 32 district health boards.

Sections 3 and 9 of *The Cancer Agency Act* provide for establishing a Saskatchewan Cancer Agency and for the Agency to coordinate a program for diagnosing, preventing and treating cancer.

The mandates of the Ministry of Health, regional health authorities and the Saskatchewan Cancer Agency are outlined in *The Department of Health Act*, *The Regional Health Services Act* and *The Cancer Agency Act*.

1.2 Reporting Relationship

The Ministry of Health is directly accountable, and regularly reports, to the Minister of Health on the funding and administering the funds for insured physician, surgical-dental and hospital services.

Section 36 of *The Saskatchewan Medical Care Insurance Act* prescribes that the Minister of Health submit an annual

report concerning the medical care insurance plan to the Legislative Assembly.

The Regional Health Services Act prescribes that each regional health authority shall submit to the Minister of Health:

- a report on the activities of the regional health authority; and
- a detailed, audited set of financial statements.

Section 54 of *The Regional Health Services Act* requires that regional health authorities and the Cancer Agency shall submit to the Minister any reports that the Minister may request from time to time. Regional health authorities and the Cancer Agency are required to submit a financial and health service plan to the Saskatchewan Ministry of Health.

1.3 Audit of Accounts

The Provincial Auditor conducts an annual audit of government ministries and agencies, including the Ministry of Health. It includes an audit of Ministry payments to regional health authorities, to the Saskatchewan Cancer Agency, and to physicians and dental surgeons for insured physician and surgical-dental services.

Section 57 of *The Regional Health Services Act* requires that an independent auditor, who possesses the prescribed qualification and is appointed for that purpose by a regional health authority and the Cancer Agency, shall audit the accounts of a regional health authority or the Cancer Agency at least once in every fiscal year. Each regional health authority and the Cancer Agency must annually submit to the Minister of Health a detailed, audited set of financial statements.

Section 34 of *The Cancer Foundation Act* prescribes that the records and accounts of the Saskatchewan Cancer Foundation shall be audited at least once a year by the Provincial Auditor or by a designated representative.

The most recent audits were for the year ended March 31, 2012.

The audits of the Government of Saskatchewan, regional health authorities and Saskatchewan Cancer Agency are tabled in the Saskatchewan Legislature each year. The reports are available to the public directly from each entity or are available on their websites.

The Office of the Provincial Auditor for Saskatchewan also prepares reports to the Legislative Assembly of Saskatchewan. These reports are designed to assist the government in managing public resources and to improve the information provided to the Legislative Assembly. They are available on the Provincial Auditor's website at: http://www.auditor.sk.ca.

2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

Section 8 of *The Regional Health Services Act* (the Act) gives the Minister the authority to provide funding to a regional health authority or a health care organization for the purpose of the Act.

Section 10 of the Act permits the Minister to designate facilities including hospitals, special care homes and health centres. Section 11 allows the Minister to prescribe standards for delivering services in those facilities by regional health authorities and health care organizations that have entered into service agreements with a regional health authority.

The Act sets out the accountability requirements for regional health authorities and health care organizations. These requirements include submitting annual operational, financial and health service plans for ministerial approval (sections 50–51); establishing community advisory networks (section 28); and reporting critical incidents (section 58). The Minister also has the authority to establish a provincial surgical registry to help manage surgical wait times (section 12). The Minister retains authority to inquire into matters (section 59); appoint a public administrator if necessary (section 60); and approve general and staff practitioner by-laws (sections 42–44).

Funding for hospitals is included in the funding provided to regional health authorities.

A comprehensive range of insured services is provided by hospitals. These may include: public ward accommodation; necessary nursing services; the use of operating room and case room facilities; required medical and surgical materials and appliances; x-ray, laboratory, radiological and other diagnostic procedures; radiotherapy facilities; anaesthetic agents and the use of anaesthesia equipment; physiotherapeutic procedures; all drugs, biological and related preparations required for hospitalized patients; and services rendered by individuals who receive remuneration from the hospital.

Hospitals are grouped into the following five categories: Community Hospitals; Northern Hospitals; District Hospitals; Regional Hospitals; and Provincial Hospitals, so people know what they can expect 24 hours a day, 365 days a year at each hospital. While not all hospitals will offer the same kinds of services, reliability and predictability means:

- it is widely understood which services each hospital offers; and
- these services will be provided on a continuous basis, subject to the availability of appropriate health providers.

Regional health authorities have the authority to change the manner in which they deliver insured hospital services based on an assessment of their population health needs, available health providers and financial resources.

The process for adding a hospital service to the list of services covered by the health care insurance plan involves a comprehensive review, which takes into account such factors as service need, anticipated service volume, health outcomes by the proposed and alternative services, cost and human resource requirements, including availability of providers as well as initial and ongoing competency assurance demands. A regional health authority initiates the process and, depending on the specific service request, it could include consultations involving several branches within the Ministry of Health as well as external stakeholder groups such as health regions, service providers and the public.

2.2 Insured Physician Services

Sections 8 and 9 of *The Saskatchewan Medical Care Insurance Act* enable the Minister of Health to establish and administer a plan of medical care insurance for provincial residents. All fee items for physicians can be found in the Physician Payment Schedule: www.health.gov.sk.ca/physician-information.

As of March 31, 2012, there were 1,985 physicians licensed to practice in the province and eligible to participate in the medical care insurance plan.

Physicians may opt out or not participate in the Medical Services Plan, but if doing so, they must fully opt out of all insured physician services. The opted-out physician must also advise beneficiaries that the physician services to be provided are not insured and that the beneficiary is not entitled to be reimbursed for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the physician is also required.

As of March 31, 2012, there were no opted-out physicians in Saskatchewan.

Insured physician services are those that are medically necessary, are covered by the Medical Services Plan of the Ministry of Health, and are listed in the Physician Payment Schedule of the Saskatchewan Medical Care Insurance Payment Regulations (1994) of *The Saskatchewan Medical Care Insurance Act*.

A process of formal discussion between the Medical Services Plan and the Saskatchewan Medical Association addresses new insured physician services and definition or assessment rule revisions to existing selected services. The Executive Director of the Medical Services Branch manages this process. When the Medical Services Plan covers a new insured physician service, or revisions to definitions or assessment rules for existing services occur, a regulatory amendment is made to the Physician Payment Schedule.

Although formal public consultations are not held, any member of the public may make recommendations about physician services to be added to the Medical Services Plan.

2.3 Insured Surgical-Dental Services

Dentists may opt out or not participate in the Medical Services Plan, but if doing so, they must opt out of all insured surgical-dental services. The dentist must also advise beneficiaries that the surgical-dental services to be provided are not insured and that the beneficiary is not entitled to reimbursement for those services. Written acknowledgement from the beneficiary indicating that he or she understands the advice given by the dentist is also required. There were no opted-out dentists in Saskatchewan as of March 31, 2012.

Insured surgical-dental services are limited to: services in connection with maxillo-facial surgery required as a result of trauma; treatment services for the orthodontic care of cleft palate; extraction of teeth when medically required for the provision of heart surgery, services for chronic renal disease, head and neck cancer services, and services for total joint replacement by prosthesis when a formal referral has been made and prior approval obtained from Medical Services Branch; and certain services in connection with abnormalities of the mouth and surrounding structures.

Surgical-dental services can be added to the list of insured services covered under the Medical Services Plan through a process of discussion and consultation with provincial dental surgeons. The Executive Director of the Medical Services Branch manages the process of adding a new service. Although formal public consultations are not held, any member of the public may recommend that surgical-dental services be added to the Medical Services Plan.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Uninsured hospital, physician and surgical-dental services in Saskatchewan include: in-patient and out-patient hospital services provided for reasons other than medical necessity; the extra cost of private and semi-private hospital accommodation not ordered by a physician; physiotherapy and occupational therapy services not provided by or under contract with a regional health authority; services provided by health facilities other than hospitals unless through an agreement with a health region and licensed under *The Health Facilities Licensing Act*; non-emergency insured hospital, physician or surgical-dental services obtained outside Canada without prior written

approval; non-medically required elective physician services; surgical-dental services that are not medically necessary; and services received under other public programs including *The Workers' Compensation Act*, the federal Department of Veteran Affairs and *The Mental Health Services Act*.

As a matter of policy and principle, insured hospital, physician and surgical-dental services are provided to residents on the basis of assessed clinical need. Compliance is periodically monitored through consultation with regional health authorities, physicians and dentists. There are no charges allowed in Saskatchewan for medically necessary hospital, physician or surgical-dental services. Charges for enhanced medical services or products are permitted only if the medical service or product is not deemed medically necessary. Compliance is monitored through consultations with regional health authorities, physicians and dentists.

Insured hospital services could be de-insured by the government if they were determined to be no longer medically necessary. The process is based on discussions among regional health authorities, practitioners, and officials from the Ministry of Health.

Insured physician services could be de-insured if they were determined not to be medically required. The process is based on consultations with the Saskatchewan Medical Association and managed by the Executive Director of the Medical Services Branch.

Insured surgical-dental services could be de-insured if they were determined not to be medically necessary. The process is based on discussion and consultation with the dental surgeons of the province, and is managed by the Executive Director of the Medical Services Branch.

Formal public consultations about de-insuring hospital, physician or surgical-dental services may be held if warranted.

3.0 UNIVERSALITY

3.1 Eligibility

The Saskatchewan Medical Care Insurance Act (sections 2 and 12) and the Medical Care Insurance Beneficiary and Administration Regulations define eligibility for insured health services in Saskatchewan. Section 11 of the Act requires that all residents register for provincial health coverage.

Eligibility is limited to residents. A "resident" means a person who is legally entitled to remain in Canada, who makes his or her home and is ordinarily present in Saskatchewan, or any other person declared by the Lieutenant Governor-in-Council to be a resident. Canadian citizens and permanent residents of Canada relocating from within Canada to Saskatchewan are generally eligible for coverage on the first day of the third month following establishment of residency in Saskatchewan.

Returning Canadian citizens, the families of returning members of the Canadian Forces, international students, and international workers are eligible for coverage on establishing residency in Saskatchewan, provided that residency is established before the first day of the third month following their admittance to Canada.

The following persons are not eligible for insured health services in Saskatchewan:

- members of the Canadian Forces and the Royal Canadian Mounted Police (RCMP), federal inmates and refugee claimants; visitors to the province[1]; and
- persons eligible for coverage from their home province or territory for the period of their stay in Saskatchewan (e.g., students and workers covered under temporary absence provisions from their home province or territory).

Such people become eligible for coverage as follows:

- discharged members of the Canadian Forces and the RCMP, if stationed in or resident in Saskatchewan on their discharge date;
- released federal inmates (this includes those prisoners who have completed their sentences in a federal penitentiary and those prisoners who have been granted parole and are living in the community); and
- refugee claimants, on receiving Convention Refugee status (immigration documentation is required).

The number of persons registered for health services in Saskatchewan on June 30, 2011, was 1,084,127.

3.2 Other Categories of Individual

Other categories of individual who are eligible for insured health service coverage include persons allowed to enter and remain in Canada under authority of a work permit, study permit or Minister's permit issued by Citizenship and Immigration Canada. Their accompanying family may also be eligible for insured health service coverage.

1. On June 29, 2012, as a result of the federal *Jobs, Growth and Long-term Prosperity Act*, the *Canada Health Act* was amended to allow members of the RCMP to be eligible for coverage under provincial and territorial health plans. At the time this report was compiled, federal, provincial and territorial governments were in consultation on the changes in provincial and territorial health legislation that would be required for members of the RCMP to be considered insured persons under provincial and territorial health insurance plans.

Refugees are eligible on confirmation of Convention status combined with a study/work permit, Minister's permit or permanent resident, that is, landed immigrant, record.

On June 30, 2011, there were 9,650 such temporary residents registered with the Saskatchewan Ministry of Health.

4.0 PORTABILITY

4.1 Minimum Waiting Period

In general, insured persons from another province or territory who move to Saskatchewan are eligible on the first day of the third month following establishment of residency. However, where one spouse arrives in advance of the other, the eligibility for the later arriving spouse is established on the earlier of a) the first day of the third month following arrival of the second spouse; or b) the first day of the thirteenth month following the establishment of residency by the first spouse.

4.2 Coverage During Temporary Absences in Canada

Section 3 of The Medical Care Insurance Beneficiary and Administration Regulations of *The Saskatchewan Medical Care Insurance Act* prescribes the portability of health insurance provided to Saskatchewan residents while temporarily absent within Canada. There were no changes to the in-Canada temporary absence provisions in 2011–2012.

Section 6.6 of *The Department of Health Act* provides the authority for paying in-patient hospital services to Saskatchewan beneficiaries temporarily residing outside the province. Section 10 of the Saskatchewan Medical Care Insurance Payment Regulations (1994) provides payment for physician services to Saskatchewan beneficiaries temporarily residing outside the province.

Continued coverage during a period of temporary absence is conditional upon the registrant's intent to return to Saskatchewan residency immediately on expiration of the approved absence period as follows:

- education: for the duration of studies at a recognized educational facility (confirmation by the facility of full-time student status and expected graduation date are required);
- employment of up to 12 months (no documentation required); and
- vacation and travel of up to 12 months.

Saskatchewan has bilateral reciprocal billing agreements with all provinces for hospital services, and all but Quebec for physician services. Payment for publicly funded Quebec physician services is made at Saskatchewan rates (Saskatchewan Physician Payment Schedule).

4.3 Coverage During Temporary Absences Outside Canada

Section 3 of the Medical Care Insurance Beneficiary and Administration Regulations of *The Saskatchewan Medical Care Insurance Act* prescribes the portability of health insurance provided to Saskatchewan residents who are temporarily absent from Canada.

Continued coverage for students, temporary workers, and vacationers and travellers during a period of temporary absence from Canada is conditional on the registrant's intent to return to Saskatchewan residence immediately on the expiration of the approved period as follows:

- education: for the duration of studies at a recognized educational facility (confirmation by the facility of full-time student status and expected graduation date are required);
- contract employment of up to 24 months; and
- vacation and travel of up to 12 months.

Section 3 of the Medical Care Insurance Beneficiary and Administration Regulations provides open-ended temporary absence coverage for persons whose principal place of residence is in Saskatchewan, but who are not able to satisfy the annual six months physical presence requirement because the nature of their employment requires travel from place to place outside Canada (e.g., cruise line workers).

Section 6.6 of *The Department of Health Act* provides the authority under which a resident is eligible for health coverage when temporarily outside Canada. In summary, a resident is eligible for medically necessary hospital services at the rate of $100 per in-patient and $50 per out-patient visit per day.

4.4 Prior Approval Requirement

Out-of-Province

The Saskatchewan Ministry of Health covers most hospital and medical out-of-province care received by its residents in Canada through a reciprocal billing arrangement. This arrangement means that residents do not need prior approval and may not be billed for most services received in other provinces or territories while travelling within Canada. The cost of travel, meals and accommodation are not covered.

Prior approval is required for the following services provided out-of-province:

- alcohol and drug, mental health, rehabilitation and problem gambling services.

Prior approval from the Ministry must be obtained by the patient's specialist.

Out-of-Country

Prior approval is required for the following services provided outside Canada:

- If a specialist physician refers a patient outside Canada for treatment not available in Saskatchewan or another province, the referring specialist must seek prior approval from the Medical Services Plan of the Ministry of Health. The Saskatchewan Cancer Agency is consulted for out-of-country cancer treatment requests. If approved, the Ministry of Health will pay the full cost of treatment, excluding any items that would not be covered in Saskatchewan.

5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

To ensure that access to insured hospital, physician and surgical-dental services are not impeded or precluded by financial barriers, extra-billing by physicians or dental surgeons and user charges by hospitals for insured health services are not allowed in Saskatchewan.

The Saskatchewan Human Rights Code prohibits discrimination in providing public services, which include insured health services, on the basis of race, creed, religion, colour, sex, sexual orientation, family status, marital status, disability, age, nationality, ancestry or place of origin.

The Saskatchewan Ministry of Health continues to place priority on promoting surgical access and improving the province's surgical system.

Sooner, Safer, Smarter: A Plan to Transform the Surgical Patient Experience was released on March 29, 2010. The plan will guide efforts to improve the surgical experience and reduce surgical wait times to a maximum of three months within four years, while ensuring shorter wait times can be sustained into the future. The four year plan is in response to recommendations in the Patient First Review, and was developed with assistance from stakeholder advisory groups. It is designed to improve the patient's experience across the entire continuum of care — from initial contact with a health provider, to surgery, to recuperation in the community.

The plan is based on five objectives: 1) shorter waits for surgical care; 2) a better experience for patients and families; 3) safe, high quality care; 4) support for good health, and 5) patient centred providers. Supporting the objectives are 25 initiatives such as increasing surgical procedures and diagnostic imaging services, offering opportunities for greater patient choice, mechanisms to improve safety, health promotion and injury prevention activities, and initiatives to support an effective health work force.

As of March 31, 2012, there were 1,985 physicians licensed to practice in the province and eligible to participate in the Medical Care Insurance Plan. Of these, 1,024 (51.6 percent) were family practitioners and 961 (48.4 percent) were specialists.

As of March 31, 2012, there were approximately 425 practising dentists and dental surgeons located in all major centres in Saskatchewan. Ninety three provided services insured under the Medical Services Plan.

In May 2009, the Government of Saskatchewan released the Physician Recruitment Strategy in an effort to address province-wide physician shortages. In 2011–2012 funding supported several recruitment initiatives:

- The provincial plan for distributed medical education continued to be developed and rolled out with the goal of increasing the number of medical seats in rural centres. Post-graduate seats were offered in Regina, Prince Albert and Swift Current.
- The Physician Recruitment Agency of Saskatchewan (saskdocs), which was created in 2009, continued to provide recruitment expertise to communities, physician practices and health agencies.
- The Saskatchewan International Physician Practice Assessment program, which worked to ensure that foreign-trained physicians are assessed with sufficient rigor to ensure patients receive safe, high-quality care while meeting the needs of communities and health regions recruiting physicians.

In addition to the initiatives noted above, the Ministry provides various practicing establishment grants, training grants, and residency positions in exchange for return-of-service commitments. The Ministry funds compensation mechanisms for emergency room coverage to ensure patients have access to emergency medical services.

There are also a number of programs to stabilize and support medical services in rural areas, such as the following:

- The Saskatchewan Medical Association is funded to provide locum relief to rural physicians through the Locum Service Program while they take vacation, education or other leave.

- The Northern Medical Services Program is a tripartite endeavour of the Ministry of Health, Health Canada and the University of Saskatchewan to help stabilize the supply of physicians in northern Saskatchewan.
- The Northern Telehealth Network provides physicians in remote or isolated areas with access to colleagues, specialty expertise and continuing education.

Other Programs

- Support is provided to initiatives for physicians to use allied health professionals and enhance the integration of medical services with other community-based services through the Alternate Payments and Primary Health Services Program.
- A Long-term Service Retention Program rewards physicians who work in the province for 10 or more years.
- The Parental Leave Program was developed in 2004 to provide benefits for self-employed physicians who take a maternity, paternity or adoption child care leave from clinical practice.

5.2 Physician Compensation

In February 2011, the Government of Saskatchewan signed a four year agreement with the Saskatchewan Medical Association covering the term of April 1, 2009 to March 31, 2013.

Section 6 of the Saskatchewan Medical Care Insurance Payment Regulations (1994) outlines the obligation of the Minister of Health to make payments for insured services in accordance with the Physician Payment Schedule and the Dentist Payment Schedule.

Fee-for-service is the most widely used method of compensating physicians for insured health services in Saskatchewan, although sessional payments, salaries, capitation arrangements and blended methods are also used. Fee-for-service is the only mechanism used to fund dentists for insured surgical-dental services. Total expenditures for in-province physician services and programs in 2011–2012 amounted to $794.9 million: $457.3 million for fee-for-service billings; $27.1 million for Specialist Emergency Coverage Programs; and $310.5 million in non-fee-for-service expenditures. There was also an additional $27.1 million for other Saskatchewan Medical Association and bursary programs.

5.3 Payments to Hospitals

Funding to regional health authorities is based on historical funding levels adjusted for inflation, collective agreement costs and utilization increases. Each regional health authority is given a global budget and is responsible for allocating funds within that budget to address service needs and priorities identified through its needs assessment processes.

Regional health authorities may receive additional funds for providing specialized hospital programs (e.g., renal dialysis, specialized medical imaging services, specialized respiratory services, and surgical services), or for providing services to residents from other health regions.

Payments to regional health authorities for delivering services are made pursuant to section 8 of *The Regional Health Services Act*. The legislation provides the authority for the Minister of Health to make grants to regional health authorities and health care organizations for the purposes of the Act, and to arrange for providing services in any area of Saskatchewan if it is in the public interest to do so.

Regional health authorities provide an annual report on the aggregate financial results of their operations.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

The Government of Saskatchewan publicly acknowledged the federal contributions provided through the Canada Health Transfer (CHT) in the Ministry's 2011–2012 Annual Report, the Government of Saskatchewan 2011–2012 Budget and related documents, its 2011–2012 Public Accounts, and the Quarterly and Mid-Year Financial Reports. These documents were tabled in the Legislative Assembly and are publicly available to Saskatchewan residents. Federal contributions have also been acknowledged on the Ministry of Health website, in news releases and issue papers, and in speeches and remarks made at various conferences, meetings and public policy forums.

REGISTERED PERSONS					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
1. Number as of March 31st (#).	1,014,649	1,035,544	1,036,284	1,070,477	1,084,127 [2]

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY [1]					
Public Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
2. Number (#).	67	67	67	66	66
3. Payments for insured health services ($).	1,277,632,000 [3]	1,402,109,000 [3]	1,556,078,000 [3]	1,636,013,000 [3]	1,694,858,000 [3]
Private For-Profit Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
4. Number of private for-profit facilities providing insured health services (#).	0	0	0	3	5
5. Payments to private for-profit facilities for insured health services ($).	0	0	0	Not Available [4]	Not Available [4]

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
6. Total number of claims, in-patient (#).	4,212	4,365	5,722	4,304	5,258
7. Total payments, in-patient ($).	31,569,400	43,631,600	53,119,000	48,700,300	59,452,700
8. Total number of claims, out-patient (#).	81,787	65,274	71,123	67,689	65,916
9. Total payments, out-patient ($).	17,240,900	17,936,200	21,497,100	21,282,400	25,410,000
INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA					
10. Total number of claims, in-patient (#).	245	251	398	295	400
11. Total payments, in-patient ($).	2,291,200	1,637,300	2,755,200	3,401,000	8,186,600
12. Total number of claims, out-patient (#).	1,381	1,437	2,189	1,992	2,646
13. Total payments, out-patient ($).	970,500	1,468,500	1,810,000	1,796,700	3,203,800

2. Saskatchewan's numbers as of June 30, 2011.
3. This number includes estimated government funding to Regional Health Authorities (RHAs) based on total projected expenditures less non-government revenue, as provided to Saskatchewan Health through the RHA annual operational plans.
   — Acute care funding includes: acute care services, specialized hospital services, and in-hospital specialist services.
   — Does not include in-patient rehabilitative care, in-patient mental health, or addiction treatment services.
   — Does not include payments to Saskatchewan Cancer Agency for out-patient chemotherapy and radiation.
4. Private surgical facilities receive payments for insured services under contracts with Regional Health Authorities. The Ministry of Health does not provide payments to these facilities.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
14. Number of participating physicians (#).	1,795	1,836	1,882	1,946	1,985
15. Number of opted-out physicians (#).	0	0	0	0	0
16. Number of non-participating physicians (#).	0	0	0	0	0
17. Total payments for services provided by physicians paid through all payment methods ($).	585,863,285	630,253,960	651,437,652	714,441,498	794,901,943
18. Total payments for services provided by physicians paid through fee-for-service ($).	379,456,739 [5,6]	401,135,717 [5,6]	410,875,422 [5,6]	457,194,531 [5,6]	457,307,474 [5]

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
19. Number of services (#).	561,415	599,106	586,621	610,328	623,778
20. Total payments ($).	25,442,417	27,753,524	29,037,662	31,505,813	32,103,002
INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA					
21. Number of services (#).	not available	not available	not available	not available	not available
22. Total payments ($).	637,600	647,700	1,299,600	1,324,100	2,279,100

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
23. Number of participating dentists (#).	82	79	70	85	93
24. Number of services provided (#).	16,347	18,085	22,349	17,800	17,420
25. Total payments ($).	1,577,176	1,840,276	2,013,007	1,827,088	1,719,770

5. Figure is composed of fee-for-service billing and funding for the Emergency Rural Coverage Program which is paid through the fee-for-service program.
6. Figures have been revised to be consistent with the Annual Statistical Report (2007–08 to 2010–11).

ALBERTA

INTRODUCTION

Alberta's Health Care System

In November 2010, the Government of Alberta released *Becoming the Best: Alberta's 5-year Health Action Plan* (Plan). In 2011–2012, Alberta's Ministry of Health (Health) supported the Plan's 5 key strategies in the following ways:

Strategy 1 — Improve access and reduce wait times

- The HealthLink Alberta public education campaign helped provide more advice to patients about urgent and emergency care options.

Strategy 2 — Provide more choice for continuing care

- Several ministries (Health, Alberta Infrastructure, Alberta Municipal Affairs) and Alberta Health Services, Alberta's health authority, are working together on a Continuing Care Implementation Plan that will address Alberta's future continuing care service needs.

Strategy 3 — Strengthen primary health care

- In May 2011, a new online health tool called MyHealth.Alberta.ca was launched as part of the Personal Health Portal initiative. The website features approximately 9,000 health topics to connect Albertans to trusted health care information and services, health tools, and wellness management tips. The website's content was reviewed by a panel of Alberta physicians and other health providers to ensure accuracy and relevancy.

Strategy 4 — Be healthy, stay healthy

- The Minister's Action on Wellness International Symposium was held in Banff, Alberta from October 11 to 13, 2011. The symposium approached wellness through healthy eating, active living, mental well-being, and addiction prevention and how research findings from these areas could be translated for practical use in Alberta.

Strategy 5 – Build one health system

- As of June 24, 2011, diagnostic images could be accessed by health care providers across Alberta through the province's electronic health record (EHR). This was a significant milestone in enhancing patient care, improving patient outcomes, and decreasing repeat exams.

1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

Health administers the Alberta Health Care Insurance Plan on a non-profit basis and in accordance with the *Canada Health Act*. Since 1969, the *Alberta Health Care Insurance Act* has governed the operation of the Alberta Health Care Insurance Plan. The Minister of Health determines which services are covered by the Alberta Health Care Insurance Plan.

1.2 Reporting Relationship

The Minister of Health is accountable for the Alberta Health Care Insurance Plan. The *Government Accountability Act* establishes the planning, reporting, and accountability structures that government and accountable organizations must adhere to.

1.3 Audit of Accounts

The Auditor General of Alberta audits all government ministries, departments, regulated funds, and provincial agencies, and is responsible for assuring the public that the government's financial reporting is credible. The Auditor General of Alberta completed its audit of Health on March 31, 2012, and indicated that the statements fairly represent, in all material respects, the financial position and results of operations for the year ended March 31, 2012.

2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

In Alberta, Alberta Health Services is the body responsible to the Minister of Health for ensuring the provision of insured hospital services. The *Hospitals Act*, the Hospitalization Benefits Regulation (AR 244/1990), the *Health Care Protection Act*, and the Health Care Protection Regulation (AR 208/2000) regulate the provision of insured services by hospitals or designated non-hospital surgical facilities. A directory of approved hospitals in Alberta can be found at: http://www.health.alberta.ca/services/health-benefits-services.html.

During 2011–2012, no amendments were made to the legislation regarding insured hospital services.

The publicly funded services provided by approved hospitals in Alberta range from the most advanced levels of diagnostic and treatment services for in-patients and out-patients, to the routine care and management of patients with previously diagnosed chronic conditions. The benefits available to hospital patients in Alberta are established in the Hospitalization Benefits Regulation (AR 244/1990). The Regulation is available at: www.health.alberta.ca/about/health-legislation.html.

There is no regular process to review insured hospital services, as the list of insured services included in the regulations is intended to be both comprehensive and generic, and does not require routine review and updating. Changes to specific physician services can be found in the Schedule of Medical Benefits, and are described in the next section.

2.2 Insured Physician Services

The *Alberta Health Care Insurance Act* governs the payment of physicians for insured physician services under the Alberta Health Care Insurance Plan (section 6). Only physicians who meet the requirements stated in the *Alberta Health Care Insurance Act* are permitted to provide insured services under the Alberta Health Care Insurance Plan.

Alberta had 7,706 physicians participating under the Alberta Health Care Insurance Plan as of March 31, 2012. Within this 6,294 physicians were paid exclusively under fee-for-service (FFS), 738 were compensated solely under an Alternate Relationship Plan (ARP) and the remaining 674 physicians received compensation from both FFS and ARP. Out of the 7,706 physicians, 2,483 participated in Primary Care Networks.

Before being registered with the Alberta Health Care Insurance Plan, a physician must complete the appropriate registration forms and include a copy of his or her license issued by the College of Physicians and Surgeons of Alberta.

Under section 8 of the *Alberta Health Care Insurance Act*, all physicians are deemed to be opted into the Alberta Health Care Insurance Plan. A physician may; however, opt out of the Alberta Health Care Insurance Plan by notifying the Minister in writing indicating the effective date of the opting out, publishing a notice of the proposed opting out in a newspaper having general circulation in the area in which the physician practices, and posting a notice of the proposed opting out in a part of the physician's office to which patients have access, at least 180 days prior to the effective date of the opting out. A physician who has opted-out must post a notice in part of the physician's office to which patients have access, advising patients of the physician's opted-out status, and ensuring that each patient is advised of their opted-out status before any service is provided to the patient. As of March 31, 2012, there were zero opted-out physicians in the province.

Section 12 of the Alberta Health Care Insurance Regulation lists services which are not insured as basic or extended health services. The Medical Benefits Regulation establishes the benefits payable for insured medical services provided to a resident of Alberta. Descriptions of those services are set out in the Schedule of Medical Benefits, which can be accessed at: http://www.health.alberta.ca/professionals/SOMB.html.

The Schedule of Medical Benefits is revised on a regular basis. Effective March 31, 2011, many amendments were made to the service and modifier descriptions in the Schedule of Medical Benefits. Examples of amendments include clarifications to the general rules, and modifiers that affect rates pertaining to certain services. All changes to the Schedule of Medical Benefits require Ministerial approval. There were no new items introduced as of April 1, 2011.

Under the 2003–2011 Tri-lateral Master Agreement, any changes to the insured physician services listed in the Schedule of Medical Benefits were the result of negotiation with Health, the Alberta Medical Association, and Alberta Health Services. The Agreement expired on March 31, 2011. There is currently no new agreement with physicians; therefore no new items have been introduced to the Schedule of Medical Benefits after March 31, 2011, nor have any rate increases been implemented.

2.3 Insured Surgical-Dental Services

In Alberta, a small number of surgical-dental services are insured. The majority of dental procedures that can be billed to the Alberta Health Care Insurance Plan can only be performed by a dentist certified as an oral and maxillofacial surgeon who meets the requirements stated in the *Alberta Health Care Insurance Act*.

Alberta insures a number of medically necessary oral surgical and dental procedures that are listed in the Schedule of Oral and Maxillofacial Surgery Benefits, available at: http://www.health.alberta.ca/professionals/allied-services-schedule.html.

Although there is no formal agreement with dentists, Health meets with members of the Alberta Dental Association and College to discuss changes to the Schedule of Oral and Maxillofacial Surgery Benefits. All changes to the benefit schedule require Ministerial approval.

Under section 7 of the *Alberta Health Care Insurance Act*, all dentists are deemed to have opted into the Plan. A dentist

may opt out of the plan by notifying the Minister of Health in writing of the effective date of their opting out and by ensuring that each patient is advised of their opted-out status before any service is provided to the patient. As of March 31, 2012, no dentists were opted-out of the Alberta Health Care Insurance Plan.

2.4 Uninsured Hospital, Physician, and Surgical-Dental Services

Section 12 of the Alberta Health Care Insurance Regulation lists services which are not insured as basic or extended health services. Section 4(2) of the Hospitalization Benefits Regulation provides a list of hospital services that are not considered to be insured. Alberta's policy for Preferred Accommodation and Non-Standard Goods or Services is available at: http://www.health.alberta.ca/newsroom/pub-health-authorities.html.

The policy describes the Government of Alberta's expectations of Alberta Health Services and guides its decision-making with respect to the provision of preferred accommodation, and enhanced or non-standard goods and services. This policy framework requires Alberta Health Services to provide 30 days advance notice to the Health Minister's designate regarding the categories of preferred accommodation offered and the charges associated with each category. Alberta Health Services is also required to provide 30 days advance notice to the Minister's designate regarding any goods or services that will be provided as non-standard goods or services. They are also required to provide information about the associated charge for these goods or services, and when applicable, the criteria or clinical indications that may qualify patients to receive it as a standard good or service.

3.0 UNIVERSALITY

3.1 Eligibility

Under the terms of the *Alberta Health Care Insurance Act*, Alberta residents are eligible to receive publicly funded health care services under the Alberta Health Care Insurance Plan. A resident is defined as a person lawfully entitled to be or to remain in Canada who makes the province his or her home and is ordinarily present in Alberta. The term "resident" does not include a tourist, transient, or visitor to Alberta. Persons moving permanently to Alberta from outside Canada are eligible for coverage if they are landed immigrants, returning landed immigrants, or returning Canadian citizens. Persons in Alberta on an approved Canada entry permit may also be eligible for coverage under the Alberta Health Care Insurance Plan, and their eligibility is reviewed on a case-by-case basis.

Residents who are not eligible for coverage under the Alberta Health Care Insurance Plan, but receive health care coverage from the federal government, include:

- Members of the Canadian Armed Forces;
- Members of the Royal Canadian Mounted Police (RCMP) who are appointed to a rank[1]; and
- Persons serving a term in a federal penitentiary.

Spouse/partner and dependants of the above are provided with Alberta Health Care Insurance Plan coverage if they are residing in Alberta.

The Alberta Health Care Insurance Plan covers persons released from the RCMP, the Canadian Armed Forces, and federal penitentiaries, effective the date of release, if notified within three months. If they are released in another part of Canada, they are eligible for coverage on the first day of the third month after becoming a resident of Alberta. During 2011–2012, no amendments were made to the legislation regarding eligibility.

In order to access insured services under the Alberta Health Care Insurance Plan, Alberta residents are required to register themselves and their eligible dependants with the Alberta Health Care Insurance Plan. Family members are registered on the same account. New residents in Alberta should apply for coverage within three months of arrival or effective dates may be affected. For persons moving from within Canada, their registration is effective on the first day of the third month after their arrival. For persons moving from outside Canada, their registration is effective the day they become an Alberta resident. The Alberta Health Care Insurance Plan process, for registering Albertans and issuing replacement health cards, requires registrants to provide documentation that proves their identity, legal entitlement to be in Canada, and Alberta residency.

As of March 31, 2012, there were 3,910,117 Alberta residents registered with the Alberta Health Care Insurance Plan. Under the *Health Insurance Premiums Act*, a resident may opt out of the Alberta Health Care Insurance Plan by filing a declaration with the Minister of Health. As of March 31, 2012, there were 216 Alberta residents who were opted-out of the Plan.

1. On June 29, 2012, as a result of the federal *Jobs, Growth and Long-term Prosperity Act*, the *Canada Health Act* was amended to allow members of the RCMP to be eligible for coverage under provincial and territorial health plans. At the time this report was compiled, federal, provincial and territorial governments were in consultation on the changes in provincial and territorial health legislation that would be required for members of the RCMP to be considered insured persons under provincial and territorial health insurance plans.

3.2 Other Categories of Individual

Persons on an approved Canada entry permit who may be eligible include those with Student or Employment Permits, Temporary Resident Permits, and Visitor Records. There were 74,046 people covered under these conditions as of March 31, 2012.

4.0 PORTABILITY

4.1 Minimum Waiting Period

Under the Alberta Health Care Insurance Plan, persons moving permanently to Alberta from another part of Canada are eligible for coverage on the first day of the third month following their arrival.

4.2 Coverage During Temporary Absences in Canada

The Alberta Health Care Insurance Plan provides coverage for eligible Alberta residents who temporarily leave Alberta for other parts of Canada. A person is considered temporarily absent from Alberta if the person stays in another province or territory for a period that will not exceed 12 consecutive months.

Individuals who are routinely absent from Alberta every year normally need to spend a cumulative total of 183 days in a 12-month period in Alberta to maintain continuous coverage. Individuals not present in Alberta for the required 183 days may be considered residents of Alberta if they satisfy Health of their permanent and principal place of residence within the province.

Alberta participates in the interprovincial hospital and medical reciprocal agreements. These agreements were established to minimize complex billing processes and to help ensure timely payments to physicians and hospitals when they provide services to residents from other provinces/territories. Quebec does not participate in the medical reciprocal agreement. Under these agreements, Alberta pays for insured services that Albertans receive in other parts of Canada at the host provincial or territorial rates.

In 2011–2012, no amendments were made to the legislation regarding portability in Canada. More information on coverage during temporary absences outside Alberta is available at: http://www.health.alberta.ca/AHCIP/outside-coverage.html.

Section 16 of the Hospitalization Benefits Regulation addresses payment for hospital services obtained outside of Alberta but within Canada. Section 4 of the Medical Benefits Regulation addresses payment of physician services obtained outside of Alberta but within Canada. These sections were not amended in 2011–2012.

4.3 Coverage During Temporary Absences Outside Canada

The Alberta Health Care Insurance Plan provides coverage to eligible Alberta residents who are temporarily absent from Canada. A person is considered to be temporarily absent from Alberta if the person stays outside Canada for a period that will not exceed six consecutive months, and the person intends to return to and maintain permanent residence in Alberta on the conclusion of their stay outside of Alberta.

Individuals who are routinely absent from Alberta every year normally need to spend a cumulative total of 183 days in a 12-month period in Alberta to maintain continuous coverage. Individuals not present in Alberta for the required 183 days may be considered residents of Alberta if they satisfy Health of their permanent and principal place of residence within the province.

The maximum amount payable for out-of-country in-patient hospital services is $100 (Canadian) per day (not including day of discharge). The maximum hospital out patient visit rate is $50 (Canadian), with a limit of one visit per day. The only exception is haemodialysis received as an out-patient, which is paid at a maximum of $461 per visit, with a limit of one visit per day. Physician and dental specialist/oral surgeon services are paid according to Alberta rates. Funding may also be available through the Out-of-Country Health Services Committee application process that will evaluate reimbursement requests made by Alberta physicians for eligible Alberta residents for medically necessary services covered under the Alberta Health Care Insurance Plan, and received in an emergency situation that were not available in Canada. More information on coverage during temporary absences outside Canada is accessible at: http://www.health.alberta.ca/AHCIP/outside-coverage.html.

Section 16 of the Hospitalization Benefits Regulation addresses payment for hospital services obtained outside of Canada. Section 5 of the Medical Benefits Regulation addresses payment of physician services obtained outside of Canada. These sections were not amended in 2011–2012.

4.4 Prior Approval Requirement

Prior approval is not required for elective insured services received in another Canadian province/territory, except for high-cost items not included in reciprocal agreements such as gamma knife surgery.

Prior application is required for elective services received out-of-country and approval may only be given through the Out-of-Country Health Services Committee for insured

services that are medically required, are not experimental, and are not available in Alberta or elsewhere in Canada.

5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

All Alberta residents have access to provincially funded and insured health services regardless of where they live in the province. Within Alberta, there are two major metropolitan zones, the Calgary zone and the Capital (Edmonton) zone, which provide provincially-funded, province-wide services to Alberta residents who need tertiary-level diagnostic and treatment services.

Alberta Health Services is responsible for overseeing the planning and delivery of health supports and services to more than three and a half million adults and children living in the province of Alberta. The board for Alberta Health Services governs all health services in the province, working in partnership with Health to ensure all Albertans have equal access to health services across the province.

Health announced, as part of its 2010–2013 Health Capital Plan, funding for several ambulatory, and primary and acute care projects designed to improve Albertans' access to insured health services. These projects include:

- The redevelopment of the Medicine Hat Regional Hospital and including renovations to create additional ambulatory treatment space.
- A new health centre in Edson, which will be built on a new site to provide health care services and programs to meet the needs of the community, including acute care, emergency, and out-patient services.
- A new health centre in High Prairie to replace the existing complex and the J.B. Wood Nursing Home. The new High Prairie Health Centre will be built on a new site and will include a wide range of health services such as acute care, continuing care, and community health programs.
- A new regional hospital in Grande Prairie, which will include a state-of-the-art cancer centre.
- The Alberta government is committed to adding 5300 continuing care spaces over the five-year period of March 2010 to March 2015.
- The launch of seven new Primary Care Networks (PCNs) throughout 2010–2011:
  - Athabasca PCN was launched on April 1, 2010;
  - Cold Lake PCN and Vegreville PCN were launched on July 1, 2010;
  - Wetaskiwin PCN and Vermilion PCN were launched on September 1, 2010;
  - Grande Prairie PCN was launched on October 1, 2010; and
  - Lloydminster PCN was launched on January 1, 2011.

As of March 31, 2011, there were 39 PCNs operating in Alberta.

5.2 Physician Compensation

The *Alberta Health Care Insurance Act* governs the payment of physicians. Most physicians are compensated through the Alberta Health Care Insurance Plan on a volume-driven, fee-for-service basis. Alternate Relationship Plans (ARPs) for specialists and family physicians offer alternative compensation models to the fee-for-service payment system. ARPs contribute to better health outcomes by supporting innovative health care delivery.

Under the 2003–2011 Tri-Lateral Master Agreement that expired on March 31, 2011, changes to physician compensation for the provision of insured services were subject to negotiation. The Agreement established overall increases to compensation under the FFS and ARP compensation types. Once overall increases were established, by virtue of the negotiated agreement, the parties undertook an allocation process in which increases were divided between the different medical specialties.

Under the Agreement, ARPs were established to enhance physician recruitment and retention, team-based approaches to service delivery, access to services, patient satisfaction, and value for money. ARPs provide predictable funding that enable physician groups to recruit new physicians to their programs and retain their services. ARPs are unique in that they offer an alternative funding model to the way government has traditionally funded health care service delivery. With the expiry of the Agreement on March 31, 2011, funding for ARPs was continued through Ministerial Order.

Beyond matters of compensation for the provision of insured services, the Agreement also contained provisions for programs involving patient access and service improvements. The Agreement established the Primary Care Initiative under which PCNs received funding. PCNs support innovative health care delivery and use a team approach to coordinate care for their patients. Family physicians work with Alberta Health Services to better integrate health services by linking to regional services such as home care. Family physicians also work with other health care providers such as nurses, dieticians, pharmacists, physiotherapists, and mental health workers who help to provide services within the PCNs. Funding for PCNs, which was extended by Health when the 2003–2011 agreement expired,

is not intended to compensate physicians for the provision of insured services although physicians can receive payment for uninsured services related to work done on behalf of the PCN.

The negotiated agreement also provided for payments to physicians under a physician on-call program, an office information technology program, direct overhead payments, and rural incentive programs. Health extended funding for these programs, as well, when the negotiated agreement expired on March 31, 2011.

As with the majority of physicians, dentists performing oral surgical services insured under the Alberta Health Care Insurance Plan are compensated through the Plan on a volume driven, fee-for-service basis. Health establishes fees through a consultation process with the Alberta Dental Association and College.

5.3 Payments to Hospitals

The *Regional Health Authorities Act* governs the funding of Alberta's single regional health authority—Alberta Health Services. Most insured hospital services in Alberta are funded through a population-based funding formula. A mental health funding grant is provided for insured services provided in mental health hospitals and for community mental health services. A funding grant is provided for insured services in cancer hospitals and to pay for cancer services that patients receive in regional hospitals. Hospitals in Edmonton and Calgary receive funding to provide highly specialized province-wide services to all Alberta residents.

Alberta's *Health Care Protection Act* governs the provision of insured surgical services performed in non-hospital surgical facilities. Ministerial approval of a contract between the facility and/or operator and Alberta Health Services is required in order for the facility to provide insured services. Ministerial designation of a non-hospital surgical facility and accreditation by the College of Physicians and Surgeons of Alberta is also required.

According to the *Health Care Protection Act*, Ministerial approval for a contractual agreement shall not be given unless:

- The insured surgical services are consistent with the principles of the *Canada Health Act*;
- There is a current and likely future need for the services in the geographical area;
- The proposed surgical services will not have a negative impact on the province's public health system;
- There will be an expected benefit to the public;
- Alberta Health Services has an acceptable business plan to pay for the services;
- The proposed agreement contains performance expectations and measures; and
- The physicians providing the services will comply with the conflict of interest and ethical requirements of the *Medical Profession Act* and bylaws.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

The Government of Alberta publicly acknowledged the federal contributions provided through the Canada Health Transfer in its 2011–2012 publications.

REGISTERED PERSONS					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
1. Number as of March 31st (#).	3,473,996	3,589,494	3,692,001	3,786,238	3,910,117

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
Public Facilities[1]	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
2. Number (#).	204	251	248	250	250
3. Payments for insured health services ($).	not available	not available	not available	not available	not avaialable
Private For-Profit Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
4. Number of private for-profit facilities providing insured health services (#).	not available	not available	not available	not available	not available
5. Payments to private for-profit facilities for insured health services ($).	not available	not available	not available	not available	not available

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
6. Total number of claims, in-patient (#).	5,334	5,447	5,411	5,689	5,707
7. Total payments, in-patient ($).	27,481,524	31,475,940	33,077,528	37,887,391	36,659,355
8. Total number of claims, out-patient (#).	101,455	104,127	105,792	110,757	109,703
9. Total payments, out-patient ($).	18,004,246	25,346,678	26,879,756	29,382,381	29,687,993
INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA[2]					
10. Total number of claims, in-patient (#).	4,014	4,762	4,506	3,075	3,613 [3]
11. Total payments, in-patient ($).	378,043	446,718	425,269	294,509	339,343 [3]
12. Total number of claims, out-patient (#).	3,934	4,305	4,544	3,425	4,414 [3]
13. Total payments, out-patient ($).	214,162	291,836	306,639	267,120	467,081 [3]

2. These data do not include claims/payments for Alberta residents who have received health services out of country through the Out-of-Country Health Services Committee application process.
3. Data reported for out of country hospital and physician services is accurate as of March 31, 2012, but does not reflect claims still being processes for 2011–2012.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
14. Number of participating physicians (#).	6,058	6,266	6,482	6,743	7,706 [4]
15. Number of opted-out physicians (#).	not applicable [5]	not applicable [5]	not applicable [5]	not applicable [5]	0
16. Number of non-participating physicians (#).	0	0	0	0	0
17. Total payments for services provided by physicians paid through all payment methods ($).	not available	not available	not available	not available	not available
18. Total payments for services provided by physicians paid through fee-for-service ($).	1,718,717,023	1,851,703,042	2,133,199,354	2,302,481,210	2,450,159,476

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
19. Number of services (#).	548,423	696,639	599,596	611,503	616,786
20. Total payments ($).	20,899,683	22,614,491	24,621,807	25,340,583	27,960,901
INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA[6]					
21. Number of services (#).	22,055	22,817	22,070	15,654	not available [7]
22. Total payments ($).	1,105,831	1,245,840	1,266,451	909,715 [7]	not available [7]

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
23. Number of participating dentists (#).	207	202	212	207	218
24. Number of services provided (#).	16,769	18,705	18,963	21,052	20,784
25. Total payments ($).	3,913,975	4,479,725	4,847,467	5,747,026	6,293,750

4. 6,294 of these are paid under fee for service (FFS), 738 under and Alternative Relationship Plan (ARP) and the remaining 674 received compensation from both FFS and ARP.
5. Alberta's legislation provides that all physicians are deemed to be participating in the Alberta Health Care Insurance Plan, unless they opt out in accordance with the procedure set out in section 8 of the *Alberta Health Care Insurance Act*. As of March 31, 2012 there were zero non-participating physicians in Alberta, as noted in indicator 16.
6. This data does not include Alberta residents who have received health services out of country through the Out-of-Country Health Services Committee application process.
7. Data for out of country hospital and physician services is still being processed for 2011–2012.

BRITISH COLUMBIA

INTRODUCTION

British Columbia has a progressive and integrated health system that includes insured services funded under the *Canada Health Act*, services funded wholly or partially by the Government of British Columbia and services regulated, but not funded, by government. The Ministry of Health (the Ministry) has overall responsibility for ensuring that quality, appropriate, and timely health services are available to all British Columbians.

The Ministry works with health authorities, care providers, agencies, and other groups to guide and enhance the province's health services, provide access to care, and ensure British Columbians are supported in their efforts to maintain and improve their health. The Ministry provides leadership, direction, and support to these service delivery partners and sets province-wide goals, standards, and expectations for health service delivery by health authorities. The province's six health authorities are the organizations primarily responsible for health service delivery. Five regional health authorities deliver a full continuum of health services to meet the needs of the population within their respective geographic regions. A sixth health authority, the Provincial Health Services Authority, is responsible for managing the quality, coordination, and accessibility of services and province-wide health programs.

The delivery of health services and the health of the population are monitored by the Ministry on an ongoing basis. These activities inform the Ministry's strategic planning and policy direction to ensure the delivery of health information and services continue to meet the needs of British Columbians. To read more about British Columbia's publicly funded health system, please refer to the BC Ministry of Health 2011–2012 Annual Service Plan Report: www.bcbudget.gov.bc.ca/Annual_Reports/2011_2012/pdf/hlth.pdf.

1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

The British Columbia Medical Services Plan (MSP) is administered by the British Columbia Ministry of Health (the Ministry). MSP insures medically required services provided by physicians and supplementary health care practitioners, laboratory services, and diagnostic procedures. The Ministry sets goals, standards, and performance agreements for health service delivery and works with the six health authorities to provide quality, appropriate, and timely health services to British Columbians. General hospital services are provided under the *Hospital Insurance Act* (section 8) and its Regulation; the *Hospital Act* (section 4); and the *Hospital District Act* (section 20).

The Medical Services Commission (MSC) manages the MSP on behalf of the Government of British Columbia in accordance with the *Medicare Protection Act* (section 3) and its Regulation. The purpose is to preserve a publicly-managed and fiscally sustainable health care system for British Columbia, in which access to necessary medical care is based on need and not on an individual's ability to pay. The function and mandate of the MSC is to facilitate reasonable access to quality medical care, health care, and diagnostic facility services for British Columbians.

The MSC is a nine-member statutory body made up of three representatives from the Government of British Columbia, three representatives from the British Columbia Medical Association (BCMA), and three members from the public jointly nominated by the BCMA and government.

In 2011–2012, the *Medicare Protection Act* was amended to support the introduction of a more secure care card, designed to improve patient safety and reduce fraud. Further, the Medical and Health Care Services Regulation was amended to bring into force this amendment to the *Medicare Protection Act* and to detail the framework of the requirement for enrolment and renewal of enrolment in MSP.

1.2 Reporting Relationship

The Medical Services Commission is accountable to the Government of British Columbia through the Minister of Health; a report is published annually for the prior fiscal year which provides an annual accounting of the business of the MSC, its subcommittees, and other delegated bodies. In addition, the MSC Financial Statement is published annually; it contains an alphabetical listing of payments made by the MSC to practitioners, groups, clinics, hospitals, and diagnostic facilities for each fiscal year.

The Ministry provides extensive information in the Annual Service Plan Report on the performance of British Columbia's publicly funded health system. Tracking and reporting this information is consistent with the Ministry's strategic approach to performance planning and reporting and is consistent with requirements contained in the provincial *Budget Transparency and Accountability Act* (2000).

In addition to the Annual Service Plan Report, the Ministry reports through various publications, including:

- Vital Statistics Annual Report;
- Provincial Health Officer's Annual Report (on the health of the population);
- Canadian Institute for Health Information reports; and
- Medical Services Commission Annual Report.

1.3 Audit of Accounts

The Ministry is subject to audit of accounts and financial transactions through:

- The Office of the Comptroller General (OCG) Internal Audit and Advisory Services; the government's internal auditor. The Comptroller General determines the scope of the internal audits and timing of the audits in consultation with the audit committee of the Ministry. The OCG reports can be located on the following website link: http://www.fin.gov.bc.ca/ocg/ias/Audit_Reports.htm.
- The Office of the Auditor General (OAG) of British Columbia is responsible for conducting annual audits as well as special audits/reports. The OAG reports its findings to the Legislative Assembly. The OAG initiates its own audits and determines the scope of its audits. The Public Accounts Committee of the Legislative Assembly reviews the recommendations of the OAG and determines if and when the Ministry has complied with the audit recommendations.

The OAG's annual audit of the Ministry's accounts and financial transactions are reflected in the OAG's overall review and opinion related to the BC Public Accounts, which can be found at the following website link: http://www.bcauditor.com/pubs/2012/special/auditor-generals-opinions-summary-financial-statements-an.

The OAG's special audits/reports can be located at the following link: http://www.bcauditor.com/pubs.

1.4 Designated Agency

The MSP of British Columbia requires premiums to be paid by eligible residents. The monies were collected by the Ministry of Finance during the 2011–2012 fiscal year.

Revenue Services of British Columbia (RSBC) performs revenue management services, including account management, billing, remittance, and collection on behalf of the Province of British Columbia (Ministry of Finance). The province remains responsible for, retains control of, and performs all government-administered collection actions.

RSBC is required to comply with all applicable laws, including:

- *Ombudsman Act* (British Columbia).
- *Business Practices and Consumer Protection Act* (British Columbia).
- *Financial Administration Act* (British Columbia).
- Freedom of Information Legislation: i.e., *Freedom of Information and Protection of Privacy Act* (British Columbia) including FOIPPA Inspections; the *Personal Information Protection Act* (British Columbia) and the equivalent federal legislation, if applicable.

Since 2005, the Ministry has contracted with MAXIMUS Canada to deliver the operations of the MSP and PharmaCare (including responding to public inquiries, registering clients, and processing medical and pharmaceutical claims from health professionals). MAXIMUS Canada administers the province's medical and drug insurance plans under the Health Insurance BC (HIBC) program. Policy and decision-making functions remain with the Ministry.

- HIBC submits monthly reports to the Ministry, reporting performance on service levels to the public and health care providers. HIBC also posts reports on its website on the performance of key service levels.
- HIBC applies payments against fee items approved by the Ministry. The Ministry approves all payments before they are released.

2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

The *Hospital Act* and Hospital Act Regulation provide authority for the Minister of Health to designate facilities as hospitals, to license private residential care hospitals, to approve the bylaws of hospitals, to inspect hospitals, and to appoint a public administrator. This legislation also establishes broad parameters for the operation of hospitals.

The *Hospital Insurance Act* and the Hospital Insurance Act Regulations provide the authority for the Minister of Health to make payments to health authorities for the purpose of operating hospitals, outlines who is entitled to receive insured services, and defines the "general hospital services" which are to be provided as benefits.

Hospital services are insured when they are provided to a beneficiary, in a publicly funded hospital, and are deemed medically required by the attending physician or midwife. There is no scheduled or regular process to review insured hospital services, as the insured services included in the regulations are intended to be comprehensive/inclusive. Uninsured services are referred to in Section 2.4 of this report.

When medically required, the following are provided to beneficiaries who are in-patients in an acute or rehabilitation hospital:

- accommodation and meals at the standard level;
- necessary nursing service;
- drugs, biologicals, and related preparations which are required by the patient and administered in hospital;
- laboratory and radiological procedures and related interpretations;
- diagnostic procedures and the necessary interpretations, as approved by the Minister;
- use of operating room, caseroom, anaesthetic facilities, routine surgical supplies, and other necessary equipment and supplies;
- use of radiotherapy facilities;
- use of physiotherapy facilities;
- services of a social worker;
- rehabilitation services including occupational and speech therapy; and
- other required services approved by the Minister, provided by persons who receive remuneration from the hospital.

When medically required, the following are provided as benefits under the *Hospital Insurance Act* or the *Medicare Protection Act* to out-patients who are beneficiaries:

- emergency department services;
- diagnostic services (e.g., laboratory or radiological procedures);
- use of operating room facilities;
- equipment and supplies used in medically necessary services provided to the beneficiary, including anaesthetics, sterile supplies, dressings, casts, splints, or immobilizers and bandages;
- meals required during diagnosis and treatment;
- drugs and medications administered in a medically-necessary service provided to the beneficiary; and
- any service provided by an employee of the hospital that is approved by the Minister.

The services are provided to beneficiaries without charge, with a few exceptions, such as incremental charges for preferred (but not medically required) medical/surgical supplies and nonstandard accommodation, and daily fees for residential care patients in extended care or general hospitals.

Some facilities providing residential care services (in this case, the term "extended care" is often used) are regulated under the *Hospital Act*. Health authorities/hospital societies are required to follow Home and Community Care policies to determine benefits in such cases.

2.2 Insured Physician Services

The range of insured physician services covered by the Medical Services Plan (MSP) includes all medically necessary diagnostic and treatment services. Insured physician services are provided under the *Medicare Protection Act* (MPA). Section 13 provides that practitioners (including medical practitioners and health care professionals, such as midwives) who are enrolled with MSP and who render benefits to a beneficiary are eligible to be paid for services rendered in accordance with the appropriate payment schedule.

Unless specifically excluded, the following medical services are insured as MSP benefits under the MPA in accordance with the *Canada Health Act*:

- medically required services provided to "beneficiaries" (residents of British Columbia who are enrolled in MSP in accordance with section 7 of the MPA) by a medical practitioner enrolled with MSP; and
- medically required services performed in an approved diagnostic facility under the supervision of an enrolled medical practitioner.

To practice in British Columbia, physicians must be registered and in good standing with the College of Physicians and Surgeons of British Columbia. To receive payment for insured services, they must be enrolled with MSP. In the fiscal year 2011–2012, 9,628 physicians were enrolled with MSP and billed fee-for-service (FFS) (includes only general practitioners and medical specialists who billed FFS in 2011–2012). In addition, some physicians practice solely on salary, receive sessional payments, or are on contract (service agreements) with the health authorities. Physicians paid by these alternative mechanisms may also practice on a FFS basis.

Practitioners other than physicians and dentists who may enrol and provide benefits under MSP include midwives, optometrists, and supplementary benefit practitioners. The Supplementary Benefits Program assists premium assistance beneficiaries to access the following services: acupuncturist, massage therapist, physiotherapist, chiropractor, naturopath,

and podiatrist (non-surgical services). The program contributes $23.00 towards the cost of each patient visit to a maximum of ten visits per patient per annum summed across the six types of providers.

A physician may choose not to enrol or to de-enrol with the Medical Services Commission (MSC). Enrolled physicians may cancel their enrolment by giving 30 days written notice to the MSC. Patients are responsible for the full cost of services provided by non-enrolled physicians. In 2011–2012, MSP had 5 opted-out physicians. Based on reclassification of information and corresponding data, British Columbia does not track non-participating physicians.

Enrolled physicians can elect to be paid directly by patients by giving written notice to the MSC. The MSC will specify the effective date between 30 and 45 days following receipt of the notice. In this case, patients may apply to MSP for reimbursement of the fee for insured services rendered.

Under the Physician Master Agreement between the government, the MSC, and the British Columbia Medical Association (BCMA), modifications to the Payment Schedule such as additions, deletions, or fee changes are made by the MSC, upon advice from the BCMA. Physicians who wish to modify the payment schedule must submit proposals to the BCMA Tariff Committee. On recommendation of the Tariff Committee, interim listings may be designated by the MSC for new procedures or other services for a limited period of time while definitive listings are established.

During fiscal year 2011–2012, physician services which were added as MSP insured benefits included 106 new fee items which reflect current practice standards, for example: 34 new fee items were in the Section of General Surgery; 21 new fee items were in the Section of General Practice; and eight new fee items were in the Section of Plastic surgery.

2.3 Insured Surgical-Dental Services

Surgical-dental services are covered by the Medical Services Plan (MSP) when hospitalization is medically required for the safe and proper completion of surgery and when they are listed in the Dental Payment Schedule. Included as insured surgical-dental procedures are those related to remedying a disorder of the oral cavity or a functional component of mastication. Generally this would include: oral surgery related to trauma; orthognathic surgery; medically required extractions; and surgical treatment of temporomandibular joint dysfunction. Additions or changes to the list of insured services are managed by MSP on the advice of the Dental Liaison Committee. Additions and changes must be approved by the MSC.

Any general dental and/or oral surgeon in good standing with the College of Dental Surgeons and enrolled in MSP may provide insured surgical-dental services in hospital. There were 218 dentists enrolled with MSP and billing FFS in 2011–2012 (includes only oral surgeons, dental surgeons, oral medicine, and orthodontists).

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Medical necessity, as determined by the attending physician and hospital, is the criterion for public funding of hospital and medical services.

In-patient and out-patient take-home drugs and any drugs not clinically approved by the hospital are excluded from coverage.

Procedures not insured under the *Hospital Insurance Act* and its regulations include: services of medical personnel not employed by the hospital; treatment for which WorkSafeBC, the Department of Veterans Affairs, or any other agency is responsible; services or treatment that the Minister, or a person designated by the Minister, determines, on a review of the medical evidence, that the beneficiary does not require; and excluded illnesses or conditions (i.e., in vitro fertilization; cosmetic service solely for the alteration of appearance; and reversal of previous sterilization procedures except when sterilization was originally caused by trauma). Uninsured hospital services also include: preferred accommodation at the patient's request; preferred medical/surgical supplies; televisions, telephones, and private nursing services; and dental care that could safely be provided in a dental office including prosthetic and orthodontic services. Insured hospital services do not include transportation between place of residence and hospital (however, health authorities are required to fund some of these services by Ministry policy, with a small user charge).

Services not insured under the MSP include: those covered by the *Workers' Compensation Act* or by other federal or provincial legislation; provision of non-implanted prostheses; orthotic devices; proprietary or patent medicines; any medical examinations that are not medically required; oral surgery rendered in a dentist's office; telephone advice unrelated to insured visits; reversal of sterilization procedures; in vitro fertilization; medico-legal services; and most cosmetic surgeries.

The *Medicare Protection Act* (section 45) prohibits the sale or issuance of health insurance by private insurers to patients for services that would be benefits if performed by a practitioner. Section 17 prohibits persons from being charged for a benefit or for "materials, consultations, procedures, and use of an office, clinic, or other place or for any other matters that relate to the rendering of a benefit."

The Ministry responds to complaints made by patients and takes appropriate actions to correct situations identified to the Ministry. The MSC determines which services are benefits and has the authority to de-list insured services. Proposals to de-insure services must be made to the MSC. Consultation may take place through a sub-committee of the MSC and usually includes a review by the BCMA's Tariff Committee. In 2011–2012, 11 obsolete fee items were removed from the Fee Schedule. The fee items removed were from the Section of the General Surgery for procedures which are now obsolete.

3.0 UNIVERSALITY

3.1 Eligibility

Section 7 of the *Medicare Protection Act* (MPA) defines the eligibility and enrolment of beneficiaries for insured services. Under the MPA, Part 2 of the Medical and Health Care Services Regulation details residency requirements. A person must be a resident of British Columbia to qualify for provincial health care benefits.

Section 1 of the MPA, defines a resident as a person who:

- is a citizen of Canada or is lawfully admitted to Canada for permanent residence;
- makes his or her home in British Columbia;
- is physically present in British Columbia at least six months in a calendar year; and
- is deemed under the regulations to be a resident.

Certain other individuals, such as some holders of permits issued under the federal *Immigration and Refugee Protection Act* are deemed to be residents (see Section 3.2 of this report), but this does not include a tourist or visitor to British Columbia.

New residents or persons re-establishing residence in British Columbia are eligible for coverage after completing a waiting period that normally consists of the balance of the month of arrival plus two months. For example, if an eligible person arrives during the month of July, coverage is available October 1. If absences from Canada exceed a total of 30 days during the waiting period, eligibility for coverage may be affected.

All residents are entitled to hospital and medical care insurance coverage. Those residents who are members of the Canadian Forces, appointed members of the Royal Canadian Mounted Police (RCMP)[1], or serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, are eligible for federally funded health insurance. The Medical Services Plan (MSP) provides first-day coverage to discharged members of the RCMP and the Canadian Forces, and to those returning from an overseas tour of duty, as well as to released inmates of federal penitentiaries.

The number of residents registered with MSP as of March 31, 2012, was 4,565,864.

3.2 Other Categories of Individual

Holders of Minister's Permits, Temporary Resident Permits, study permits, and work permits are eligible for benefits when deemed to be residents under the *Medicare Protection Act* and section 2 of the Medical and Health Care Services Regulation.

3.3 Premiums

The enabling legislation is:

- *Medicare Protection Act* (British Columbia), Part 2 — Beneficiaries section 8; and
- Medical and Health Care Services Regulation (British Columbia) Part 3 — Premiums.

Enrolment in MSP is mandatory and payment of premiums is ordinarily a requirement for coverage. However, failure to pay premiums is not a barrier to coverage for those who meet the basic enrolment eligibility criteria. Monthly premiums for MSP since January 1, 2012, are $64.00 for one person, $116.00 for a family of two, and $128.00 for a family of three or more.

Residents with limited incomes may be eligible for premium assistance. There are five levels of assistance, ranging from 20 to 100 percent of the full premium. Premium assistance is available only to beneficiaries who, for the last 12 consecutive months, have resided in Canada and are either a Canadian citizen or a holder of permanent resident (landed immigrant) status under the federal *Immigration and Refugee Protection Act*.

4.0 PORTABILITY

4.1 Minimum Waiting Period

New residents or persons re-establishing residence in British Columbia are eligible for coverage after completing a waiting period that normally consists of the balance of the month of

1. Although outside the 2011–12 fiscal year reporting period, for clarity purposes Health Canada notes that "On June 29, 2012, as a result of the federal Bill C-38, now the *Jobs, Growth and Long-term Prosperity Act*, the *Canada Health Act* was amended to allow members of the RCMP to be eligible for coverage under provincial and territorial health plans. At the time this report was compiled, federal, provincial and territorial governments were in consultation on the changes in provincial and territorial health legislation that would be required for members of the RCMP to be considered insured persons under provincial and territorial health insurance plans."

arrival plus two months. For example, if an eligible person arrives during the month of July, coverage is available October 1. If absences from Canada exceed a total of 30 days during the waiting period, eligibility for coverage may be affected. New residents from other parts of Canada are advised to maintain coverage with their former medical plan during the waiting period.

4.2 Coverage during Temporary Absences in Canada

Sections 3, 4 and 5 of the Medical and Health Care Services Regulation of the *Medicare Protection Act* define portability provisions for persons temporarily absent from British Columbia with regard to insured services. In 2011–2012, there were no amendments to the Medical and Health Care Services Regulation with respect to portability provisions.

Individuals leaving the province temporarily on extended vacations, or for temporary employment, may be eligible for coverage for up to 24 months. Approval is limited to once in five years for absences exceeding six months in a calendar year. Residents who spend part of every year outside British Columbia must be physically present in Canada at least six months in a calendar year and continue to maintain their home in British Columbia in order to retain coverage. When a beneficiary stays outside British Columbia longer than the approved period, they will be required to fulfill a waiting period upon returning to the province before coverage can be renewed. Students attending a recognized school in another province or territory on a full-time basis are entitled to coverage for the duration of their studies.

According to interprovincial and interterritorial reciprocal billing arrangements, physicians, except in Quebec, bill their own medical plans directly for services rendered to eligible Medical Services Plan (MSP) British Columbia residents, upon presentation of a valid CareCard. British Columbia then reimburses the province or territory at the rate of the fee schedule in the province or territory in which services were rendered. For in-patient hospital care, services are paid at the ward rate approved for each hospital by the Assistant Deputy Ministers Policy Advisory Committee. For out-patient services, the payment is at the interprovincial and interterritorial reciprocal billing rate. Payment for these services, except for excluded services that are billed to the patient, is handled though interprovincial and interterritorial reciprocal billing procedures.

Quebec does not participate in reciprocal billing agreements for physician services. As a result, claims for services provided to British Columbia beneficiaries by Quebec physicians must be handled individually. When travelling in Quebec (or outside of Canada) the beneficiary is usually required to pay for medical services and seek reimbursement later from MSP.

British Columbia pays host provincial rates for insured services according to rates established by the Interprovincial Health Insurance Agreements Coordinating Committee.

4.3 Coverage During Temporary Absences Outside Canada

The enabling legislation that defines portability of health insurance during temporary absences outside Canada is stated in the *Hospital Insurance Act*, section 24; the Hospital Insurance Act Regulations, Division 6; the *Medicare Protection Act*, section 51; and the Medical and Health Care Service Regulation, sections 3, 4, 5.

Residents who leave British Columbia temporarily to attend school or university may be eligible for MSP coverage for the duration of their studies, provided they are in full-time attendance at a recognized educational facility and are enrolled in a program which leads to a degree or certificate recognized in Canada. Generally, beneficiaries who have been studying outside of BC must return to the province by the end of the month following the month in which studies are completed. Any student who will not return to British Columbia within that timeframe, and who has been away for less than 24 months, should contact MSP.

Residents who spend part of every year outside British Columbia must be physically present in Canada at least six months in a calendar year and continue to maintain their home in British Columbia in order to retain coverage. However, because of the increasing demand for a specialized and mobile work force employed for short-term contracts and assignments, exceptions may be made to enable coverage for up to 24 consecutive months of absence while temporarily outside British Columbia. Approval is limited to once in five years for absences that exceed six months in a calendar year. In addition, if a person's employment requires them to routinely travel outside of British Columbia for more than six months per calendar year they can apply for approval to maintain their eligibility.

British Columbia residents who are temporarily absent from British Columbia and cannot return due to extenuating health circumstances are deemed residents for an additional 12 months if they are visiting in Canada or abroad. This also applies to the person's spouse and children provided they are with the person and they are also residents or deemed residents.

4.4 Prior Approval Requirement

No prior approval is required for elective procedures that are covered under the interprovincial reciprocal agreements with other provinces. Prior approval from the Medical Services

Commission (MSC) is required for procedures that are not covered under the reciprocal agreements.

The physician services excluded under the Interprovincial Agreements for the Reciprocal Processing of Out-of-Province Medical Claims are: surgery for alteration of appearance (cosmetic surgery); gender reassignment surgery; surgery for reversal of sterilization; therapeutic abortions; routine periodic health examinations including routine eye examinations; in vitro fertilization, artificial insemination; acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy; services to persons covered by other agencies (e.g., RCMP, Canadian Armed Forces, Workers' Compensation Board, Department of Veterans Affairs, Correctional Services of Canada); services requested by a "third party"; team conference(s); genetic screening and other genetic investigation, including DNA probes; procedures still in the experimental/developmental phase; and anaesthetic services and surgical assistant services associated with all of the foregoing.

The services on this list may or may not be reimbursed by the home province. The patient should make inquiries of that home province after direct payment to the British Columbia physician. Some treatments (e.g., treatment services in not-for-profit residential facilities) may require the recommendation of the Health Authorities Division of the Ministry of Health.

All non-emergency procedures performed outside Canada require approval from the MSC before the procedure.

5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

Beneficiaries in British Columbia, as defined in section 1 of the *Medicare Protection Act*, are eligible for all insured hospital and medical care services as required. To ensure equal access to all, regardless of income, the *Medicare Protection Act*, sections 17 and 18, prohibits extra-billing by enrolled practitioners.

Access to Insured Physician and Dental-Surgical Services

Access to insured services continues to be enhanced:

- In 2011–2012, approximately 3,000 general practitioners (GPs) and specialists received all or part of their income through British Columbia's Alternative Payments Program (APP). APP funds regional health authorities to contract with or hire physicians, in order to deliver insured clinical services.
- The Full-Service Family Practice Incentive Program has been expanded as the Ministry of Health (the Ministry) and physicians continue to work together to develop incentives aimed at helping to support and sustain full service family practice.
- The Ministry provides funding through the Medical On-Call Availability Program to health authorities to enable them to contract with groups of physicians to provide "on-call" coverage necessary for hospitals to deliver emergency health care services to unassigned patients in a reliable, effective, and efficient manner.
- The Ministry continued and implemented several programs under the 2002 Subsidiary Agreement for Physicians in Rural Practice, which were continued in the Physician Master Agreement (PMA) to enhance the availability and stability of physician services in smaller urban, rural, and remote areas of British Columbia. These programs include:
  - Rural Retention Program — provides eligible physicians (estimated at 1,800) with fee premiums. It is available to resident and visiting physicians and locums, and also provides a flat fee sum for eligible physicians who reside and practice in a rural community.
  - Isolation Allowance Fund — provides funding to communities with fewer than four physicians and no hospital, and where the Medical On-Call Availability Program, Call-back, or Doctor of the Day payments is not available.
  - Northern and Isolation Travel Assistance Outreach Program — provides funding support for approved physicians who visit rural and isolated communities to provide medical service(s).
  - Rural General Practitioner Locum Program — assists rural general practitioners in taking reasonable periods of leave from their practices by providing up to 43 days of paid locum coverage per year. This program assisted physicians in approximately 56 small communities to attend continuing medical education and also provided vacation relief.
  - Rural Specialist Locum Program — assists rural specialists in taking vacations and continuing medical education by providing paid locum support. The program provided locum support for core specialists in 10 rural communities to provide vacation relief and assistance while physician recruitment efforts were underway.
  - Rural Emergency Enhancement Fund — provides funding to support eligible rural communities for physician groups that commit to work as a team to maintain public access to Emergency Department services in rural hospitals.
  - Rural Education Action Plan — supports the training needs of physicians in rural practice through several components, including rural practice experience for medical students and enhanced skills for practicing physicians.

- Rural Continuing Medical Education — offers eligible rural physicians funding support to acquire and maintain medical skills and expertise for rural practice. The amount is dependent upon the designation of the community and the length of time the physician has practiced in the community.
- Recruitment Incentive Fund — provides an incentive to physicians to fill vacancies that are part of the Physician Supply Plan in eligible rural communities.
- Rural Loan Forgiveness Program — decreases British Columbia student loans by 20 percent for each year of rural practice for physicians, nurse practitioners, nurses, midwives, and pharmacists.

Infrastructure and Capital Planning

British Columbia continues to make strategic investments in health sector capital infrastructure. The Ministry invests annually to renew and extend the asset life of existing health facilities, medical and diagnostic equipment, and information management technology at numerous health facilities across British Columbia. The Ministry has developed a ten year capital plan to ensure health infrastructure is maintained and renewed within expected asset lifecycle timelines.

The Ministry has committed to a significant number of major capital projects at hospitals in locations including Surrey, Victoria, Abbotsford, Vancouver, Prince George, Vernon, Kelowna, Courtenay/Comox, Campbell River, and Fort St. John, developed as public-private partnerships. Major capital projects are overseen by Project Boards comprised of senior executives from health authorities and government to ensure projects are appropriately defined and stay within their approved scope, cost, and completion schedules.

5.2 Physician Compensation

The PMA is a formal agreement signed by the Government of British Columbia, the British Columbia Medical Association (BCMA), and the Medical Services Commission (MSC). As of March 31, 2012 (the fiscal year deadline for the 2011–2012 Canada Health Act report submission), the province and the BCMA were in negotiations regarding the ratification of the renewal of the PMA[2].

In general terms, the PMA provides the framework for managing the ongoing relationship between the government, health authorities, physicians, and the BCMA. Its Subsidiary Agreements provide additional detail related to:

- Physician benefits (the Benefits Subsidiary Agreement) — outlines programs that provide contractually negotiated benefits.
- Rural programs (the Rural Practice Subsidiary Agreement) — provides financial incentives for physicians to locate to and establish their practice in rural and remote communities.
- Alternative Payment Programs (The Alternative Payments Subsidiary Agreement) — outlines the specific terms and conditions applicable to alternative payment agreements.
- Programs specific to GPs (General Practitioner Subsidiary Agreement) and Specialists (Specialist Subsidiary Agreement) — establishes the General Practitioners Services Committee, the Specialist Services Committee, and the Shared Care Committee.

The PMA gives the BCMA exclusive right to represent the interests of all physicians who receive payment for the medical services they provide to persons insured through the Medical Services Plan (MSP). The PMA establishes mechanisms which promote enhanced collaboration and accountabilities between the province and the BCMA through various joint committees. It also provides formal conflict management process at both the local and provincial levels and language limiting physician service withdrawals. The role of health authorities in the planning and delivery of health care services are reinforced in the PMA.

The PMA establishes the compensation and benefit structure for physicians who provide publicly funded medical services whether on a fee-for-service or alternate funding methods (service contracts, salaries, and sessional arrangements). Through the PMA, the province also provides targeted financial support for such areas as: rural physician incentive programs; access to specialist services; supporting full service family practices; and shared care models involving GPs, specialists, and other healthcare professions.

Physicians are licensed under the *Health Professions Act* with their Payment Schedule established under section 26 of the *Medicare Protection Act*. The agreement provides processes for monitoring and managing the funding established by the MSC for allocation under section 25 of the *Medicare Protection Act* for insured medical services provided by physicians on a fee-for-service basis. Mechanisms for revisions to the Payment Schedule and for the payment of physicians are detailed in the PMA.

Dentists are licensed under the *Health Professions Act*. The province and the British Columbia Dental Association (BCDA) negotiated a Memorandum of Understanding in

2. Although outside the scope of the 2011/12 fiscal year reporting period, British Columbia notes that in July 2012, doctors in BC ratified a new four-year agreement that will support ongoing efforts to recruit and retain physicians, while also improving access to specialists and care in rural and remote communities. For further information, please see the Government of British Columbia News Release: http://www2.news.gov.bc.ca/news_releases_2009-2013/2012HLTH0077-001081.htm

2010 that is effective through March 2012 and covers the following services: dental surgery; oral surgery; orthodontic services; oral medicine; and dental technical procedures. Both the province and the BCDA agree to meet through a Joint Dental Surgery Policy Committee for the duration of the agreement.

Compensation Methods for Physicians and Dentists

Payment for medical services delivered in the province is made through the Medical Services Plan to individual physicians, based on submitted claims, and through the Alternative Payment Program (APP) to health authorities for physicians' services. In 2011–2012, over 73 percent of medical expenditures were distributed as fee-for-service and 11 percent were distributed as alternative payments. Of the alternative payments, 78 percent were distributed through contracts, 20 percent as sessions (3.5-hour units of service), and two percent as salaried arrangements. The government funds health authorities for alternative payments; it does not pay physicians directly. In British Columbia, for dentistry services, MSP pays for medically required dental services and medically required dental surgical services performed in a hospital; the rest is self-pay.

5.3 Payments to Hospitals

Funding for hospital services is included in the annual funding allocation and payments made to regional health authorities. This funding allocation is to be used to fund the full range of necessary health services for the population of the region (or for specific provincial services, for the population of British Columbia), including the provision of hospital services. The *Hospital Insurance Act* and its related regulations govern payments made by the health care plan to health authorities. This statute establishes the authority of the Minister to make payments to hospitals, and specifies in broad terms what services are insured when provided within a hospital.

The hospitals' portion of the funding allocation is not specified; however, the exception to this rule is funding targeted for specific priority projects (e.g., reduction in wait times for hips and knees, and patient-focused funding). For these types of initiatives, funding is provided to health authorities rather than hospitals and it is specifically earmarked and must be reported on separately.

The Ministry of Health introduced patient-focused funding in 2010–2011 under which a significant portion of eligible acute care funding is based on actual workload performed. The Ministry continued the Patient-Focused Funding (PFF) initiative in 2011–2012 and health authorities participated in the PFF initiatives, such as Emergency Department Pay-for-Performance; Procedural Care Programs (e.g., Magnetic Resource Imaging); Community Programs; Activity Based Funding; and National Surgical Quality Improvement.

Annual funding allocations to health authorities are determined as part of the Ministry's annual budget process in consultation with the Ministry of Finance and Treasury Board. The final funding amount is conveyed to health authorities by means of an annual funding letter.

Insured hospital services are included within the annual funding allocations to health authorities, as well as specific targeted funding from time to time. Incremental funding is allocated to health authorities using the Ministry's Population Needs-Based Funding Formula and other funding allocation methodologies (e.g., to reflect targeted funding allocations directed to specific health authorities). The annual funding allocation to health authorities does not include funding for programs directly operated by the Ministry, such as the payments to physicians and payments for prescription drugs covered under PharmaCare.

The accountability mechanisms associated with government funding for hospitals is part of several comprehensive documents which set expectations for health authorities. These are the annual funding letter, annual service plans, and annual Government Letters of Expectations. Taken together, these documents convey the Ministry's broad expectations for health authorities and explain how performance will be monitored in relation to these expectations. In 2011–2012, a full continuum of care (acute, residential, community care, public and preventive health, adult mental health, addictions programs, etc.) was provided through five regional health authorities and the Provincial Health Services Authority (responsible for province-wide programs).

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

Funding provided by the federal government through the Canada Health Transfer is recognized and reported by the Government of British Columbia through various government websites and provincial government documents. In 2011–2012, these documents included:

- Estimates, Fiscal Year Ending March 31, 2012, available at: http://www.bcbudget.gov.bc.ca/2012/estimates/2012_Estimates.pdf.
- 2011–2012 Budget and Fiscal Plan, which includes the 2011–2012 Third Quarterly Report, available at: http://www.bcbudget.gov.bc.ca/2011/bfp/2011_Budget_Fiscal_Plan.pdf.
- Public Accounts 2011–2012, available at: http://www.fin.gov.bc.ca/ocg/pa/11_12/Pa11_12.htm.

REGISTERED PERSONS					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
1. Number as of March 31st (#).	4,335,676	4,402,540	4,469,177	4,521,503	4,565,864

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
Public Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
2. Number (#).[3]	120 [3]	119 [3]	119 [3]	119 [3]	120 [3]
3. Payments for insured health services ($).[4]	not available	not available	not available	not available	not available
Private For-Profit Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
4. Number of private for-profit facilities providing insured health services (#).	not available	not available	not available	not available	not available
5. Payments to private for-profit facilities for insured health services ($).	not available	not available	not available	not available	not available

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
6. Total number of claims, in-patient (#).	7,160	7,102	6,846	5,909	6,551
7. Total payments, in-patient ($).	55,309,733	64,550,692	64,655,739	67,078,612	69,785,313
8. Total number of claims, out-patient (#).	95,677	95,326	87,948	78,075	86,544
9. Total payments, out-patient ($).	19,088,368	24,262,195	24,188,890	21,830,298	25,327,347
INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA					
10. Total number of claims, in-patient (#).	1,603	1,963	3,056	2,469	2,961
11. Total payments, in-patient ($).	14,486,341	11,811,654	6,058,867	4,452,628	4,152,060
12. Total number of claims, out-patient (#).	1,215	1,630	1,920	1,940	2,468
13. Total payments, out-patient ($).	553,661	967,704	1,174,112	999,733	1,301,179

General information for statistical indicators 1-2: Historical and current data may differ from report to report because of changes in data sources, definitions and methodology from year to year. The count of facilities in this table may not match counts produced from the Discharge Abstract Database, the MIS reporting system, or the *Societies Act* because each reporting system has different approaches to counting multiple site facilities and categorizing them by function.

3. As per the guidelines, the number of public facilities in this table excludes psychiatric hospitals and extended care facilities.

4. BC Ministry of Health Funding to Health Authorities for the provision of the full range of regionally delivered services are as follows: $7.1 billion in 2006–2007, $7.6 billion in 2007–2008, $8.2 billion in 2008–2009, $8.6 billion in 2009–2010, $9.2 billion in 2010–2011 and $9.7 billion in 2011–2012.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
14. Number of participating physicians as of March 31st (#).	8,772 [5]	8,986 [5]	9,201 [5]	9,417 [5]	9,628 [5]
15. Number of opted-out physicians as of March 31st (#).	5	5	5	5	5
16. Number of not participating physicians as of March 31st (#).	2	2	2	not available [6]	not available [6]
17. Total payments for services provided by physicians paid through all payment methods ($).	not available	not available	not available	not available	not available
18. Total payments for services provided by physicians paid through fee-for-service ($).	2,234,652,895 [7]	2,334,513,866 [7]	2,460,935,638 [7]	2,541,874,909 [7]	2,619,943,719 [7]

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
19. Number of services (#).	725,130	736,007	622,390	626,034	651,682
20. Total payments ($).	26,465,248	28,703,587	29,591,918	30,779,981	32,421,561
INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA					
21. Number of services (#).	84,204	82,654	75,909	82,076	66,506
22. Total payments ($).	4,379,977	4,528,521	4,014,813	4,119,511	3,592,313

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
23. Number of participating dentists as of March 31st (#).	245	249	243	236	218
24. Number of services provided as of March 31st (#).	43,262	46,736	50,341	51,036	52,047
25. Total payments as of March 31st ($).	6,305,343	7,289,302	8,093,266	7,991,262	8,130,009

5. The number of participating physicians in item 14 is for physicians who received payments through Fee-For-Service.
6. Based on reclassification of information and corresponding data, BC does not track non-participating physicians. Data for item number 16 is not available.
7. The MSP Fee-For-Service payments in item 18 are restated to include medical services referred to medical practitioners by midwives or nurse practitioners.

YUKON

INTRODUCTION

The health care insurance plans operated by the Government of Yukon are the Yukon Health Care Insurance Plan (YHCIP) and the Yukon Hospital Insurance Services Plan (YHISP). The YHCIP is administered by the Director, as appointed by the Executive Council Member (Minister of Health and Social Services). The YHISP is administered by the Administrator, as appointed by the Commissioner in Executive Council (Commissioner of the Yukon Territory). The Director of the YHCIP and the Administrator of the YHISP are hereafter referred to as the Director, Insured Health and Hearing Services. References in this text to the "Plan" refer to either the Yukon Health Care Insurance Plan or the Yukon Hospital Insurance Services Plan.

The objective of the Yukon Health Care System is to ensure access to, and portability of, insured physician and hospital services according to the provisions of the *Health Care Insurance Plan Act* and the *Hospital Insurance Services Act*. The Minister, Health and Social Services, is responsible for delivering all insured health care services. Service delivery is administered centrally by the Department of Health and Social Services.

Other insured services provided to eligible Yukon residents include the Children's Drug and Optical Program; the Chronic Disease and Disability Benefits Program; the Pharmacare and Extended Benefits Programs; and the Travel for Medical Treatment Program. Non-insured health service programs include Community Health; Community Nursing; Continuing Care; and Mental Health Services.

In February 2009, the Yukon government launched a four-year Licensed Practical Nurse (LPN) program at Yukon College to encourage Northerners who are interested in pursuing a career in a medical profession to remain in Yukon. Training LPNs locally is helping address Yukon's demand for health care professionals, particularly in continuing care and home care.

In 2010, the Yukon government introduced a motion to develop a Wellness Strategy to promote healthy living habits for all Yukoners. This strategy will focus on children and youth, healthy aging, and social inclusion, with the goal of improving overall health outcomes and reducing health disparities.

The Yukon Hospital Corporation is investing approximately $70 million for three major infrastructure projects: the now completed Crocus Ridge Place, which is a residence for visiting health care professionals and staff office complex in Whitehorse; and the construction of two new Regional Hospitals in Dawson City (anticipated opening is Spring 2013) and Watson Lake (anticipated opening is Spring 2013).

The Yukon government is also utilizing modern technology to improve health care services for Yukoners. It has invested in tele-radiology to provide computer radiology in 13 Community Health Centres across the territory, and has expanded the Telehealth video conferencing equipment capabilities within the First Nations health offices.

The Department of Health and Social Services introduced the Weight Wise program to the territory in the Fall of 2010. A local physician and nurse were trained to deliver the program by Alberta Health Services, which also provides the 10 module re-education program to its obese clients. In 2012, a psychologist was added to support clients as they navigate the weight wise program. The program is designed to help clients achieve a healthy weight in order to reduce medical complications for the client and reduce potential costs to the healthcare system. Since the introduction, Yukon has extended an intake for 15 clients every six month. To date, 95 clients have participated in the program and an additional 101 are currently wait listed.

Finally, Yukon established a Referred Care Clinic to support a number of complex "orphan" patients who are without the services of a family physician (general care needs) and who may also present with compounding addictions, pain management or mental health care needs. Historically, this patient group has relied on the Whitehorse General Hospital Emergency Department (WGH ER) to meet their care needs resulting in growing pressure on the sole acute care facility in Whitehorse.

1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

The *Health Care Insurance Plan Act*, section 3(2) and section 4, establishes the public authority to operate the health medical care plan. There were no amendments made to these sections of the Act in 2011–2012.

The *Hospital Insurance Services Act*, section 3(1) and section 5, establishes the public authority to operate the health hospital care plan. There were no amendments made to these sections of the Act in 2011–2012.

Subject to the *Health Care Insurance Plan Act* (section 5) and regulations, the mandate and function of the Director, Insured Health and Hearing Services, is to:

- develop and administer the Plan;
- determine eligibility for entitlement to insured health services;
- register persons in the Plan;
- make payments under the Plan, including the determination of eligibility and amounts;
- determine the amounts payable for insured health services outside the Yukon;
- establish advisory committees and appoint individuals to advise or assist in the operation of the plan;
- conduct actions and negotiate settlements in the exercise of the Government of Yukon's right of subrogation under the Act to the rights of insured persons;
- conduct surveys and research programs and obtain statistics for such purposes;
- establish what information is required to be provided under the Act and the form that information must take;
- appoint inspectors and auditors to examine and obtain information from medical records, reports, and accounts; and
- perform any other functions and discharge any other duties assigned by the Minister of Health and Social Services under the Act.

Subject to the *Hospital Insurance Services Act* (section 6) and the regulations, the mandate and function of the Director, Insured Health and Hearing Services, is to:

- develop and administer the hospital insurance plan;
- determine eligibility for and entitlement to insured services;
- determine the amounts that may be paid for the cost of insured services provided to insured persons;
- enter into agreements on behalf of the Government of Yukon with hospitals in or outside of Yukon, or with the Government of Canada or any province or an appropriate agency thereof, for the provision of insured services to insured persons;
- approve hospitals for the purposes of the Act;
- conduct surveys and research programs and obtain statistics for those purposes;
- appoint inspectors and auditors to examine and obtain information from hospital records, reports, and accounts;
- prescribe the forms and records necessary to carry out the provisions of the Act; and
- perform any other functions and discharge any other duties assigned to the administrator by the Regulations.

1.2 Reporting Relationship

The Department of Health and Social Services is accountable to the Legislative Assembly and the Government of Yukon through the Minister.

Section 6 of the *Health Care Insurance Plan Act* and section 7 of the *Hospital Insurance Services Act* require that the Director, Insured Health and Hearing Services, make an annual report to the Minister of Health and Social Services respecting the administration of the two health insurance plans. A Statement of Revenue and Expenditures is tabled in the legislature and is subject to discussion at that level. The last Annual Report presented by the Director of Insured Health and Hearing Services to the Minister of Health and Social Services was for the 2010–2011 fiscal year. The 2012–2013 Annual Report will be provided in the fall of 2013.

1.3 Audit of Accounts

The Health Care Insurance Plan and the Hospital Insurance Services Plan are subject to audit by the Office of the Auditor General of Canada. The Auditor General of Canada is the auditor of the Government of Yukon in accordance with section 30 of the *Yukon Act* (Canada). The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government of Yukon. Further, the Auditor General of Canada is to report to the Yukon Legislative Assembly any matter falling within the scope of the audit that, in his or her opinion, should be reported to the Assembly.

Regarding the Yukon Hospital Corporation, section 13(2) of the *Hospital Act* requires every hospital to submit a report of the operations of the Corporation for that fiscal year; the report is to include the financial statements of the Corporation and the auditor's report. The report is to be provided to the Department of Health and Social Services within six months of the end of each fiscal year.

2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

The *Hospital Insurance Services Act*, sections 3, 4, 5 and 9, establish authority to provide insured hospital services to insured residents. The Yukon Hospital Insurance Services Ordinance was first passed in 1960 and came into effect April 9, 1960. There were no amendments made to these sections of the legislation in 2011–2012.

In 2011–2012, insured in-patient and out-patient hospital services were delivered in 15 facilities throughout the territory. These facilities include one general hospital, one hospital and 13 health centres. Adopted on December 7, 1989, the *Hospital Act* establishes the responsibility of the legislature and the government to ensure "compliance with appropriate methods of operation and standards of facilities and care". Adopted on November 11, 1994, the Hospital Standards Regulation sets out the conditions under which all hospitals in the territory are to operate. Section 4(1) provides for the Ministerial appointment of one or more investigators to report on the management and administration of a hospital. Section 4(2) requires that the hospital's Board of Trustees establish and maintain a quality assurance program.

Currently, the Yukon Hospital Corporation operates under a three-year accreditation through Accreditation Canada. Whitehorse General Hospital successfully received accreditation until 2014. In addition, the Yukon Hospital Corporation assumed responsibility for Watson Lake Hospital which also successfully completed the accreditation primer for 2012.

The Yukon government assumed responsibility for operating health centres from the federal government in April 1997. These facilities, including the Watson Lake Cottage Hospital, operate in compliance with the adopted Medical Services Branch Scope of Practice for Community Health Nurses/ Nursing Station Facility/ Health Centre Treatment Facility, and the Community Health Nurse Scope of Practice. The General Duty Nurse Scope of Practice was completed and implemented in February 2002.

Pursuant to the Hospital Insurance Services Regulations, section 2(e) and (f), services provided in an approved hospital are insured. Section 2(e) defines in-patient insured services as all of the following services to in-patients, namely: accommodation and meals at the standard or public ward level; necessary nursing service; laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of an injury, illness or disability; drugs, biologicals and related preparations as provided in Schedule B of the regulations, when administered in the hospital; use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies; routine surgical supplies; use of radiotherapy facilities where available; use of physiotherapy facilities where available; and services rendered by persons who receive remuneration therefore from the hospital.

Section 2(f) of the regulations defines "out-patient insured services" as all of the following services to out-patients, when used for emergency diagnosis or treatment within 24 hours of an accident, which period may be extended by the Administrator, provided the service could not be obtained within 24 hours of the accident, namely: necessary nursing service; laboratory, radiological and other diagnostic procedures, together with the necessary interpretations for the purpose of assisting in the diagnosis and treatment of an injury; drugs, biologicals and related preparations as provided in Schedule B, when administered in a hospital; use of operating room and anaesthetic facilities, including necessary equipment and supplies; routine surgical supplies; services rendered by persons who receive remuneration therefore from the hospital; use of radiotherapy facilities where available; and use of physiotherapy facilities where available.

Pursuant to the Hospital Insurance Services Regulations, all in-patient and out-patient services provided in an approved hospital by hospital employees are insured services. Standard nursing care, pharmaceuticals, supplies, diagnostic and operating services are provided. Any new programs or enhancements with significant funding implications or reductions to services or programs require the prior approval of the Minister, Health and Social Services. This process is managed by the Director, Insured Health and Hearing Services. Public representation regarding changes in service levels is made through membership on the hospital board.

Similar to the 2010–2011 fiscal year, the Government of Yukon continues to provide additional funds to assist patients with recourse options who have orthopaedic (knees and hip) or ophthalmology surgery requirements.

In addition, Yukon remains committed to the administration of the Weight Wise program in Whitehorse. In previous years, clients were sent to Alberta to participate in the program. With the help of Alberta Health Services, a local physician and a local registered nurse have been trained in delivering the program in-territory. The first intake of clients began in the fall of 2010.

These measures will help reduce Yukon's reliance on out-of-territory services.

2.2 Insured Physician Services

Sections 1 to 8 of the *Health Care Insurance Plan Act* and sections 2, 3, 7, 10 and 13 of the Health Care Insurance Plan Regulations provide for insured physician services. There were no amendments made to these sections of the legislation in 2011–2012.

The Yukon Health Care Insurance Plan covers physicians providing medically required services. In order to participate in the Yukon Health Care Insurance Plan, physicians must:

- register for licensure pursuant to the *Health Professions Act*; and
- maintain licensure, pursuant to the *Health Professions Act*.

The number of resident physicians participating in the Yukon Health Care Insurance Plan in 2011–2012 was 74.

Section 7 of the Yukon Health Care Insurance Plan Regulations covers payment for medical services. Subsection 4 allows physicians to make arrangements for payment for insured services on a basis other than a fee for services rendered. Notice in writing of this election must be submitted to the Director, Insured Health and Hearing Services. In 2011–2012, no physicians provided written notice of their election to collect fees other than from the Yukon Health Care Insurance Plan.

Insured physician services in Yukon are defined as medically required services rendered by a medical practitioner.

The process used to add a new fee to the Payment Schedule for Yukon is administered through a committee structure. This process requires physicians to submit requests in writing to the Yukon Health Care Insurance Plan/Yukon Medical Association Liaison Committee.

Following review by this committee, a decision is made to include or exclude the service. The relevant costs or fees are normally set in accordance with similar costs or fees in other jurisdictions. Once a fee-for-service value has been determined, notification of the service and the applicable fee is provided to all Yukon physicians. Public consultation is not required.

Alternatively, new fees can be implemented as a result of the fee negotiation process between the Yukon Medical Association and the Department of Health and Social Services. The Director, Insured Health and Hearing Services, manages this process and no public consultation is required.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the health care insurance plan of Yukon must be licensed pursuant to the *Dental Professions Act* and are given billing numbers to bill the Yukon Health Care Insurance Plan for providing insured dental services. The Plan is also billed directly for services provided outside the territory.

Insured dental services are limited to those surgical-dental procedures listed in Schedule B of the Health Care Insurance Plan Regulations. The procedures must be performed in a hospital.

The addition or deletion of new surgical-dental services to the list of insured services requires amendment by Order-in-Council to Schedule B of the Health Care Insurance Plan Regulations. Coverage decisions are made on the basis of whether or not the service must be provided in hospital under general anaesthesia. The Director, Insured Health and Hearing Services, administers this process.

There were no new insured surgical-dental services added in 2011–2012.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Only services prescribed by and rendered in accordance with the *Health Care Insurance Plan Act* and regulations and the *Hospital Insurance Services Act* and regulations are insured. All other services are uninsured.

Uninsured hospital services include: non-resident hospital stays; special/private nurses requested by the patient or family; additional charges for preferred accommodation unless prescribed by a physician; crutches and other such appliances; nursing home charges; televisions; telephones; and drugs and biologicals following discharge. (These services are not provided by the hospital.)

Section 3 of the Yukon Health Care Insurance Plan Regulations contains a non-exhaustive list of services that are prescribed as non-insured. Uninsured physician services include: advice by telephone; medical-legal services; testimony in court; preparation of records, reports, certificates and communications; services or examinations required by a third party; services, examinations or reports for reasons of attending university or camp; examination or immunization for the purpose of travel, employment or emigration; cosmetic services; services not medically required; giving

or writing prescriptions; the supply of drugs; dental care except procedures listed in Schedule B; and experimental procedures.

Uninsured dental services include: procedures considered restorative; and procedures that are not performed in a hospital under general anaesthesia.

All Yukon residents have equal access to services. Third parties, such as private insurers or the Worker's Compensation Health and Safety Board, do not receive priority access to services through additional payment. The purchase of non-insured services, such as fibreglass casts, does not delay or prevent access to insured services at any time. Insured persons are given treatment options at the time of service.

Yukon has no formal process to monitor compliance; however, feedback from physicians, hospital administrators, medical professionals and staff allows the Director, Insured Health and Hearing Services, to monitor usage and service concerns.

Physicians in Yukon may bill patients directly for non-insured services. Block fees are not used at this time; however, some do bill by service item. Billable services include, but are not limited to: completion of employment forms; medical-legal reports; transferring records; third-party examinations; some elective services; and telephone prescriptions, advice or counselling. Payment does not affect patient access to services because not all physicians or clinics bill for these services and other agencies or employers may cover the cost.

The process used to de-insure services covered by the Yukon Health Insurance Plan is as follows:

- Physician services — the Yukon Health Care Insurance Plan/Yukon Medical Association Liaison Committee is responsible for reviewing changes to the Payment Schedule for Yukon, including decisions to de-insure certain services. In consultation with the Yukon Medical Advisor, decisions to de-insure services are based on medical evidence that indicates the service is not medically necessary, is ineffective or a potential risk to the patient's health. Once a decision has been made to de-insure a service, all physicians are notified in writing. The Director, Insured Health and Hearing Services, manages this process. No services were removed in 2011–2012.
- Hospital services — an amendment by Order-In-Council to sections 2(e) and 2(f) of the Yukon Hospital Insurance Services Regulations would be required. As of March 31, 2012, no insured in-patient or out-patient hospital services, as provided for in the regulations, have been de-insured. The Director, Insured Health and Hearing Services, is responsible for managing this process in conjunction with the Yukon Hospital Corporation.
- Surgical-dental services — an amendment by Order-In-Council to Schedule B of the Health Care Insurance Plan Regulations is required. A service could be de-insured if determined not medically necessary or is no longer required to be carried out in a hospital under general anaesthesia. The Director, Insured Health and Hearing Services, manages this process. No surgical-dental services were de-insured in 2011–2012.

3.0 UNIVERSALITY

3.1 Eligibility

Eligibility requirements for insured health services are set out in the *Health Care Insurance Plan Act* and regulations, sections 2 and 4 respectively, and the *Hospital Insurance Services Act* and regulations, sections 2 and 4 respectively. No changes were made to these sections of the legislation in 2011–2012. Subject to the provisions of these Acts and regulations, every Yukon resident is eligible for and entitled to insured health services on uniform terms and conditions. The term "resident" is defined using the wording of the *Canada Health Act* and means a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in Yukon, but does not include a tourist, transient or visitor. Where applicable, the eligibility of all persons is administered in accordance with the Interprovincial Agreement on Eligibility and Portability.

Under section 4(1) of both regulations, "an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory." All persons returning to or establishing residency in Yukon are required to complete this waiting period. The only exception is for children adopted by insured persons, and for newborns.

The following persons are not eligible for coverage in Yukon:

- persons entitled to coverage from their home province or territory (e.g., students and workers covered under temporary absence provisions);
- visitors to Yukon;
- refugee claimants;
- convention refugees;
- inmates in federal penitentiaries;
- study permit holders, unless they are a child and they are listed as the dependent of a person who holds a one year work permit; and
- employment authorizations of less than one year.

The above persons may become eligible for coverage if they meet one or more of the following conditions:

- establish residency in Yukon;
- become a permanent resident; or
- For inmates at the Whitehorse Correctional Centre, the day following discharge or release if stationed in or resident in Yukon.

The number of registrants on the Yukon Health Care Insurance Plan as of March 31, 2012 was 36,694.

3.2 Other Categories of Individual

The Yukon Health Care Insurance Plan provides health care coverage for other categories of individuals, as follows:

- Returning Canadians — waiting period is applied
- Permanent Residents — waiting period is applied
- Minister's Permit — waiting period is applied, if authorized
- Foreign Workers — waiting period is applied, if holding Employment Authorization
- Clergy — waiting period is applied, if holding Employment Authorization

Employment Authorizations must be in excess of 12 months.

4.0 PORTABILITY

4.1 Minimum Waiting Period

Pursuant to section 4(1) of the Yukon Health Care Insurance Plan Regulations and the Yukon Hospital Insurance Services Regulations, "an insured person is eligible for and entitled to insured services after midnight on the last day of the second month following the month of arrival to the Territory." All persons entitled to coverage are required to complete the minimum waiting period with the exception of children adopted by insured persons (see section 3.1), and newborns.

4.2 Coverage During Temporary Absences in Canada

The provisions relating to portability of health care insurance during temporary absences outside Yukon, but within Canada, are defined in sections 5, 6, 7 and 10 of the Yukon Health Care Insurance Plan Regulations and sections 6, 7(1), 7(2) and 9 of the Yukon Hospital Insurance Services Regulations.

The regulations state that, "where an insured person is absent from the Territory and intends to return, he is entitled to insured services during a period of 12 months continuous absence." Persons leaving Yukon for a period exceeding three months are advised to contact Yukon Insured Health Services and complete a Temporary Absence Form. Failure to do so may result in cancellation of coverage.

Students attending educational institutions full-time outside Yukon remain eligible for the duration of their academic studies. The Director of Insured Health and Hearing Services may approve other absences in excess of 12 consecutive months upon receiving a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director.

For temporary workers and missionaries, the Director of Insured Health and Hearing Services may approve absences in excess of 12 consecutive months upon receiving a written request from the insured person. Requests for extensions must be renewed yearly and are subject to approval by the Director.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Interprovincial Agreement on Eligibility and Portability effective February 1, 2001. Definitions are consistent in regulations, policies and procedures. No amendments were made to these sections of the legislation in 2011–2012.

The Yukon participates fully with the Inter-Provincial Medical Reciprocal Billing Agreements and Hospital Reciprocal Billing Agreements in place with all other provinces and territories with the exception of Quebec, which does not participate in the medical reciprocal billing arrangement. Persons receiving medical (physician) services in Quebec may be required to pay directly and submit claims to the Yukon Health Care Insurance Plan for reimbursement.

The Hospital Reciprocal Billing Agreements provide for payment of insured in-patient and out-patient hospital services to eligible residents receiving insured services outside Yukon, but within Canada.

The Medical Reciprocal Billing Agreements provide for payment of insured physician services on behalf of eligible residents receiving insured services outside Yukon, but within Canada. Payment is made to the host province at the rates established by that province.

Insured services provided to Yukon residents while temporarily absent from the territory, are paid at the rates established by the host province.

4.3 Coverage During Temporary Absences Outside Canada

The provisions that define portability of health care insurance to insured persons during temporary absences outside Canada are defined in sections 5, 6, 7, 9, 10 and 11 of the Yukon Health Care Insurance Plan Regulations and sections 6, 7(1), 7(2) and 9 of the Yukon Hospital Insurance Services Regulations.

No amendments were made to these sections of the legislation in 2011–2012. Sections 5 and 6 state that, "where an insured person is absent from Yukon and intends to return, he is entitled to insured services during a period of 12 months continuous absence."

Persons leaving Yukon for a period exceeding three months are advised to contact Yukon Health Care Insurance Plan and complete a Temporary Absence form. Failure to do so may result in cancellation of the coverage.

The provisions for portability of health insurance during out-of-country absences for students, temporary workers and missionaries are the same as for absences within Canada (see section 4.2 of this report).

Insured physician services provided to eligible Yukon residents temporarily outside the country are paid at rates equivalent to those paid had the service been provided in Yukon. Reimbursement is made to the insured person by the Yukon Health Care Insurance Plan or directly to the provider of the insured service.

Insured in-patient hospital services provided to eligible Yukon residents outside Canada are paid at the rate established in the Standard Ward Rates Regulation for the Whitehorse General Hospital.

Insured out-patient hospital services provided to eligible Yukon residents outside Canada are paid at the rate established in the Charges for Out-Patient Procedures Regulation.

4.4 Prior Approval Requirement

There is no legislated requirement that eligible residents must seek prior approval before seeking elective or emergency hospital or physician services outside Yukon or outside Canada.

5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

There are no user fees or co-insurance charges under the Yukon Health Care Insurance Plan or the Yukon Hospital Insurance Services Plan. All services are provided on a uniform basis and are not impeded by financial or other barriers. There is no extra-billing in the Yukon for any services covered by the Plan.

Access to hospital or physician services not available locally are provided through the Visiting Specialist Program, Telehealth Program or the Travel for Medical Treatment Program. These programs ensure that there is minimal or no delay in receiving medically necessary services.

To improve access to insured health services, the number of visiting specialists was increased to better serve patients in the territory. The Department has also provided Yukon women better access to obstetric services through the newly established Women's Clinic.

5.2 Physician Compensation

The Department of Health and Social Services seeks its negotiating mandate from the Government of Yukon, before entering into negotiations with the Yukon Medical Association (YMA). The YMA and the government each appoint members to the negotiating team. Meetings are held as required until an agreement has been reached. The YMA's negotiating team then seeks approval of the tentative agreement from the YMA membership. The Department seeks ratification of the agreement from the Government of Yukon. The final agreement is signed with the concurrence of both parties.

The Memorandum of Understanding expired on March 31, 2012. Negotiations were ratified on October 18, 2012, which now provides for a new five year physician funding agreement.

The legislation governing payments to physicians and dentists for insured services are the *Health Care Insurance Plan Act* and the Health Care Insurance Plan Regulations. No amendments were made to these sections of the legislation in 2011–2012.

The fee-for-service system is used to reimburse the majority of physicians providing insured services to residents. Other systems of reimbursement include contract payments and sessional payments.

5.3 Payments to Hospitals

The Government of Yukon funds the Yukon Hospital Corporation (Whitehorse General Hospital) through global contribution agreements with the Department of Health and Social Services. Global operations and maintenance (O&M) and capital funding levels are negotiated and adjusted based on operational requirements and utilization projections from prior years. In addition to the established O&M and capital funding set out in the agreement, provision is made for the

hospital to submit requests for additional funding assistance for implementing new or enhanced programs.

Only the Whitehorse General Hospital is funded directly through a contribution agreement. The Watson Lake Cottage Hospital and all health centres are funded through the Government of Yukon budget process.

The legislation governing payments made by the health care plan to facilities that provide insured hospital services is the *Hospital Insurance Services Plan Act* and regulations. The legislation and regulations set out the legislative framework for payment to hospitals for insured services provided by that hospital to insured persons. No amendments were made to these sections of the legislation in 2011–2012.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

The Government of Yukon has acknowledged the federal contributions provided through the Canada Health Transfer (CHT) in its 2011–2012 annual Main Estimates and Public Accounts publications, which are available publicly. Section 3(1)(d) and (e) of the *Health Care Insurance Plan Act* and section 3 of the *Hospital Insurance Services Act* acknowledge the contribution of the Government of Canada.

REGISTERED PERSONS					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
1. Number as of March 31st (#).	33,423	33,983	35,084	36,063	36,694

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
Public Facilities[1]	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
2. Number (#).	15	15	15	15	15
3. Payments for insured health services ($).[2]	44,573,638	49,051,490	51,734,000	57,655,576	58,943,422
Private For-Profit Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
4. Number of private for-profit facilities providing insured health services (#).	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services ($).	0	0	0	0	0

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
6. Total number of claims, in-patient (#).	976	1,013	956	1,047	996
7. Total payments, in-patient ($).[3]	10,742,393	11,183,888	15,333,983	16,583,657	13,507,016
8. Total number of claims, out-patient (#).	9,027	9,983	12,830	13,197	13,550
9. Total payments, out-patient ($).	2,155,225	2,888,247	3,248,555	3,413,932	3,974,870
INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA					
10. Total number of claims, in-patient (#).	15	13	19	25	20
11. Total payments, in-patient ($).	32,075	12,003	67,671	45,893	100,716
12. Total number of claims, out-patient (#).	74	40	92	74	77
13. Total payments, out-patient ($).	11,782	8,233	18,862	12,741	21,950

1. Public facilities are the 13 health centres (Beaver Creek, Destruction Bay, Carcross, Carmacks, Dawson, Faro, Haines Junction, Mayo, Old Crow, Pelly Crossing, Ross River, Teslin and Whitehorse) and 2 hospitals (Whitehorse and Watson Lake).
2. Includes monies paid to hospitals and community nursing stations
3. Hospitals have up to a year from date of service to bill jurisdictions. (information is based upon date of service; therefore, 2011–12 reporting period is still open until March 31, 2013)

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
14. Number of participating physicians (#).	67	67	69	69	74
15. Number of opted-out physicians (#).	0	0	0	0	0
16. Number of non-participating physicians (#).	0	0	0	0	0
17. Total payments for services provided by physicians paid through all payment methods ($).	16,342,282	19,139,117	20,781,850	21,549,640	22,387,839
18. Total payments for services provided by physicians paid through fee-for-service ($).[4]	14,127,399	16,294,365	17,719,117	17,701,880	18,373,627

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
19. Number of services (#).	38,512	45,744	50,893	54,007	53,915
20. Total payments ($).	1,977,052	2,297,501	3,008,828	3,185,612	3,219,166
INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA					
21. Number of services (#).	not available	not available	not available	not available	not available
22. Total payments ($).	not available	not available	not available	not available	not available

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY[5]	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
23. Number of participating dentists (#).	3	4	4	2	3
24. Number of services provided (#).	4	23	4	4	14
25. Total payments ($).	4,433	25,602	6,271	4,631	13,913

4. Includes Visiting Specialists, Member Reimbursements, Locum Doctors, and Optometrist testing paid through fee-for-service. Excludes services and costs provided by alternative payment agreements.
5. Includes direct billings for insured surgical-dental services received outside the territory.

NORTHWEST TERRITORIES

INTRODUCTION

The Department of Health and Social Services (the Department) along with six regional Health and Social Service Authorities, the Tlicho Community Services Agency and the Stanton Territorial Health Authority, plan, manage, deliver and evaluate a full repertoire of health and social services at both the community and facility level throughout the Northwest Territories.

During the 2011–2012 fiscal year the Department carried out the following activities:

- All extended health benefits are now provided through Alberta Blue Cross. During the previous fiscal year some extended health benefits were provided by Alberta Blue Cross and others were provided directly through the Department of Health and Social Services.
- A new *Health Information Act* is being drafted. This new Act will provide up-to-date health-specific access, and protection of privacy provisions that will apply to health care providers, including private sector providers, such as pharmacies. This will include standards for consent and notice, provisions for access for research and system planning, as well as information systems management.
- A new *Health and Social Services Professions Act* is being developed. This Act will regulate several health and social services professions under one legislative model, thereby allowing the Department to modernize existing outdated professional legislation in a more efficient and consistent manner. Professions currently unlicensed in the Northwest Territories could also be regulated under the Act in the future.
- In 2011–2012, work was done to amend the Long Term Care fee prescribed in the Hospital Insurance Regulations under the *Hospital Insurance and Health and Social Services Administration Act* to adjust for inflation. Work had also begun on a long term solution to establish a Long Term Care rate that could be adjusted for inflation without further amendment to the Regulations.

More information on the Department's legislative initiatives is available in the Health and Social Services Annual Report, released in the fall of 2012.

1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

The Northwest Territories Health Care Plan consists of the Medical Care Plan and the Hospital Insurance Plan. The Medical Care Plan is administered by the public authority of the Director of Medical Insurance, as appointed by the Minister of Health and Social Services (hereafter referred to as the Minister) under the *Medical Care Act*. The Minister administers the Hospital Insurance Plan through each Health and Social Service Authorities' board of management as per section 10 of the *Hospital Insurance and Health and Social Services Administration Act* (HHHSSA). Legislation that enables the Health Care Insurance Plan within the NWT includes the *Medical Care Act* and the HHHSSA.

1.2 Reporting Relationship

Reporting to the Minister; the Department, the six regional Health and Social Service Authorities (HSSAs), the Tlicho Community Services Agency (TCSA) and the Stanton Territorial Health Authority, plan, manage, deliver and evaluate a full repertoire of health and social services at both the community and facility level throughout the NWT.

The Minister appoints the Director of Medical Insurance who is responsible for administering the *Medical Care Act* and its regulations. The Director reports to the Minister any matters concerning the operational status of the Medical Care Plan.

The Minister, through the Boards of Management, administers the Hospital Insurance Plan. Each HSSA is administered by a Minister appointed Board of Management. The Boards manage, control and operate health and social services within the current parameters, resources and policies. Board members serve for three years, with exception of the chairperson whose term is indeterminate.

The TCSA has a Board in which each Tlicho community is represented by one appointed person who may serve a tenure of up to four years. The chairperson on the Board is appointed by the Minister of Aboriginal Affairs and Intergovernmental Relations in consultation with the members appointed by each community government. The Minister of Aboriginal Affairs and Intergovernmental Relations decides and fixes the length of the chairperson's term.

The Director of Medical Insurance and the Boards of Management are responsible to the Minister, as per section 8(1)(b) of the *Canada Health Act*.

1.3 Audit of Accounts

As part of the Government of the Northwest Territories annual audit, the Office of the Auditor General of Canada audits payments under the Hospital Insurance Plan and the Medical Care Plan.

2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

Insured hospital services in the Northwest Territories (NWT) are provided under the *Hospital Insurance and Health and Social Services Administration Act*.

During the reporting period, insured hospital services were provided to in- and out-patients by 4 hospitals and 23 health centers throughout the NWT. Consistent with Section 9 of the *Canada Health Act*, the NWT provides an exhaustive list of services to provide care to its residents.

Insured in-patient hospital services include:

- meals and accommodation at the ward level;
- required nursing services;
- laboratory, diagnostic and imaging services (along with necessary interpretations);
- drugs, biologicals and other preparations prescribed by a physician;
- surgical supplies and use of operating room;
- case room and anaesthesiology services;
- radiology and rehab therapy (physio, audio, occupational and speech);
- psychiatric and psychological services within an approved program; and
- detoxification at approved centers.

Insured out-patient hospital services include:

- laboratory tests;
- diagnostic imaging (including interpretations when needed);
- physiotherapy, speech and language pathology therapy and occupational therapy;
- minor medical and surgical procedures and related supplies; and
- psychiatric and psychological services under an approved hospital program.

Travel assistance is provided for residents who require medically necessary procedures that are not offered in their community or elsewhere within the NWT. Medical Travel Assistance (as outlined in the Medical Travel Policy) provides barrier free access to care services and procedures for the residents of the NWT in accordance with the *Canada Health Act*.

The Minister may change, add or delete insured hospital services, and determine whether public consultation will occur.

2.2 Insured Physician Services

The NWT *Medical Care Act* and the NWT Medical Care Regulations provide NWT residents insurance for physician services. Physicians, nurse practitioners and midwives provide insured services under the *Medical Profession Act*, *Nursing Profession Act* and the *Midwifery Act*, respectively; all of whom are required by legislation to be licensed to practise in the NWT. As of March 31, 2012, there were 285 physicians licensed in the NWT.

Physicians may opt out and collect fees other than under the Medical Care Plan by providing written notice to the Director of Medical Insurance. There are no opted-out physicians in the NWT.

The Medical Care Plan insures all medically necessary physician services such as:

- diagnostics and therapeutics;
- surgical supplies and services;
- eye examinations provided by a licensed ophthalmologist;
- obstetrics; and
- specialist visits with proper approval from a medical practitioner.

The Director of Medical Insurance is responsible for recommending a tariff for services payable by the NWT Medical Care Plan, though it is the Minister who ultimately

determines if services will be added, altered or deleted from insured physician services by:

- establishing a medical care plan that provides insured services to insured persons by medical practitioners that will qualify and enable the NWT to receive payments of contributions from the Government of Canada under the *Canada Health Act*; and
- approving the fees and charges itemized in the tariff that may be paid in respect to insured services rendered by medical practitioners, whether in or outside the NWT, and the conditions under which fees and charges are payable.

2.3 Insured Surgical-Dental Services

Licensed oral surgeons may submit claims for insured surgical-dental work in the NWT. The Province of Alberta's Schedule of Oral and Maxillofacial Surgery Benefits is used as a guide.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Not all services provided by hospitals, medical practitioners and dentists are covered under the Health Care Plan. Some uninsured services include:

- in-vitro fertilization;
- third party examinations;
- dental services that are not surgical in nature;
- group immunizations;
- medical-legal services;
- advice or prescriptions done over the phone;
- services rendered to the physician's family;
- dressings, bandages, drugs and other consumables used at the medical practitioner's office;
- eye glasses and other appliances;
- plaster; and
- services carried out by people who usually are not medical practitioners such as osteopaths, naturopaths and chiropractors. Physiotherapy, psychiatry and psychological therapies are not covered if delivered in a non-approved location.

For NWT residents to receive items and/or services that are generally considered uninsured under the health care plan, prior approval is required. A Medical Advisor makes recommendations to the Director of Insured Services regarding the appropriateness of the request.

The Workers' Safety and Compensation Committee has several policies that are applied when interpreting the *Workers' Compensation Act(s)*. These policies are available on their website at www.wscc.nt.ca.

The process used to make changes to the list of uninsured hospital, physician and surgical-dental services is described in sections 2.1 and 2.2 of this report.

3.0 UNIVERSALITY

3.1 Eligibility

The Northwest Territories (NWT) uses the Health Care Plan Registration Guidelines, defined in the *Medical Care Act*, in accordance with the Interprovincial Agreement on Eligibility and Portability, to determine eligibility and fulfill obligations of section 10 in the *Canada Health Act*.

Ineligible individuals for NWT health care coverage are members of the Canadian Forces, the Royal Canadian Mounted Police (RCMP), federal inmates and new residents who have not completed the minimum waiting period. For persons moving back to Canada, eligibility is restored when permanent residency is established.

On June 29, 2012, as a result of the federal *Jobs, Growth and Long-term Prosperity Act*, the *Canada Health Act* was amended to allow members of the RCMP to be eligible for coverage under provincial and territorial health plans. At the time this report was compiled, federal, provincial and territorial governments were in consultation on the changes in provincial and territorial health legislation that would be required for members of the RCMP to be considered insured persons under provincial and territorial health insurance plans.

In order to register, residents fill out an application form and provide applicable documentation (e.g. visa, immigration papers, proof of residency if requested). Residents may register prior to eligibility. Registration is directly linked to eligibility and claims are only paid if the client has registered.

As of March 31, 2012 there were 44,216 individuals registered with the NWT Health Care Plan.

No formal terms exist for clients to opt out of the NWT Health Care Plan.

3.2 Other Categories of Individuals

Holders of employment visas, student visas and, in some cases, visitor visas are covered if they meet the provisions of the Eligibility and Portability Agreement and Guidelines for health care plan coverage.

4.0 PORTABILITY

4.1 Minimum Waiting Period

Waiting periods for persons moving to the Northwest Territories (NWT) are consistent with the Interprovincial Agreement on Eligibility and Portability. The waiting period ends the first day of the third month of residency for those moving permanently to the NWT, or the first day of the thirteenth month for those whose work term was for one year and has been extended. Confirmation of extension may be required.

4.2 Coverage During Temporary Absences in Canada

Section 4(2) of the *Medical Care Act* provides NWT residents with access to insured health coverage while temporarily out of the NWT but still in Canada, in accordance with section 11(1)(b)(i) of the *Canada Health Act*. The Department adheres to the Interprovincial Agreement on Eligibility and Portability as described in the NWT Health Care Plan Registration Guidelines.

Once an individual has filled out the Temporary Absence form and it is approved by the Department, NWT residents are covered for up to one year to leave for work, travel or holidays. Full time students attending post-secondary school are covered as well. The full cost of insured services is paid for all services received in other jurisdictions.

With an NWT health care card, most medical practitioner visits and hospital services are billed directly to the Department. Reimbursement guidelines exist for patients having to pay up front for medically required services. During the reporting period over 19 million dollars were paid out for hospital in-patient and out-patient services in other provinces and territories.

The NWT participates in both the Hospital Reciprocal Billing Agreement and the Medical Reciprocal Billing Agreement with other jurisdictions (except Quebec).

4.3 Coverage During Temporary Absences Outside Canada

Through the *Medical Care Act*, section 4(3), the NWT Health Care Plan Registration Guidelines provide criteria that define medical practitioner and hospital fees payable for costs incurred by NWT residents while they are out of Canada on a temporary basis.

Per section 11(1)(b)(ii) of the *Canada Health Act* the NWT provides reimbursement for NWT residents who require medically necessary services while temporarily outside Canada. Individuals are required to pay up front and seek reimbursement upon their return to the NWT. Services rendered outside of Canada will not be reimbursed in excess of amounts payable when the benefit is rendered in the NWT.

Residents temporarily out of Canada may receive coverage for up to one year; however, prior approval is required as well as documentation proving the NWT will be the individual's permanent residence upon return.

4.4 Prior Approval Requirement

Prior approval is required for elective services rendered in other provinces and outside of Canada. All services from private facilities require prior approval as well.

5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

The Medical Travel Program provides barrier free access to necessary medical services for Northwest Territories (NWT) residents, in accordance with section 12(1)(a) of the *Canada Health Act*. The Medical Travel Program, through an approval process, guarantees rural residents access to regional or territorial centers for services not available in the individual's community, and all NWT residents access to services not offered in the NWT through contractual agreements with southern health authorities.

Telehealth services increase accessibility to insured health services throughout the territory. Every community in the NWT now has access to Telehealth. The only exception is the hamlet of Enterprise, which shares services with neighbouring Hay River. All NWT residents, including those in isolated communities, have access to all Government of the Northwest Territories (GNWT) facilities via the Medical Travel Program and Telehealth, including access to specialists, rehabilitation professionals and other medical practitioners. In 2011–2012 the number of trained Home Support Workers was increased to enable authorities to increase the hours available to clients allowing for evening/weekend coverage and/or to increase staffing levels at peak times. This was critical as the NWT health and social services system needed to respond to the new 48-hour rapid discharge of patients from Alberta.

Extra-billing is not permitted in the NWT, in adherence to section 14 of the *Canada Health Act*. The only exception is if a medical practitioner opts out of the Medical Care Plan and collects his or her own fees. This did not occur during the reporting period.

5.2 Physician Compensation

The NWT Medical Association and the Department negotiate physician compensation. Generally, family practitioners are compensated through contractual agreements with the GNWT, while the remainder are mostly compensated on a fee-for-service basis as determined under the NWT *Medical Care Act*.

5.3 Payments to Hospitals

Contribution agreements between the Department of Health and Social Services and the Boards of Management for each Health and Social Service Authority (HSSA), Stanton Territorial Health Authority and the Tlicho Community Services Agency dictate payments made to hospitals. Government budgets, resources and levels of services offered determine the allocated amounts.

Payments to HSSAs providing insured hospital services are governed under the *Hospital Insurance and Health and Social Services Administration Act* and the *Financial Administration Act*. A comprehensive budget is used to fund hospitals in the Northwest Territories.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

Federal Funding from the Canada Health Transfer has been recognized and reported by the GNWT through press releases and other documents.

For the current reporting period these documents include:

- 2011–2012 Budget Address;
- 2011–2012 Main Estimates;
- 2011–2012 Public Accounts;
- 2011–2012 Business Plan for the Department of Health and Social Services;
- 2011–2012 Business Plan for the Department of Finance; and
- The Main Estimates report (noted above) is presented annually to the Legislative Assembly and represents the government's financial plan.

All data are subject to future revisions. 2011–2012 estimates are based on claim data as of September 21, 2012.

REGISTERED PERSONS					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
1. Number as of March 31st (#).	45,927	46,699	47,544	43,639	44,216

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
Public Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
2. Number (#).	27	27	27	27	27
3. Payments for insured health services ($).	85,365,096	74,254,097	74,626,037	69,607,096	79,157,702
Private For-Profit Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
4. Number of private for-profit facilities providing insured health services (#).	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services ($).	not applicable	not applicable	not applicable	not applicable	not applicable

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
6. Total number of claims, in-patient (#).	1,198	1,174	1,104	1,098	1,095
7. Total payments, in-patient ($).	12,824,618	13,157,987	12,312,420	14,793,910	15,004,206
8. Total number of claims, out-patient (#).	11,915	12,355	11,588	10,576	11,263
9. Total payments, out-patient ($).	2,742,122	3,574,665	3,473,391	3,517,806	3,959,643
INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA					
10. Total number of claims, in-patient (#).	8	11	8	7	12
11. Total payments, in-patient ($).	41,786	24,078	33,175	54,896	38,898
12. Total number of claims, out-patient (#).	43	39	44	53	38
13. Total payments, out-patient ($).	6,666	13,642	13,774	31,185	19,524

All data are subject to future revisions.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
14. Number of participating physicians (#).	286 [1]	276 [1]	282 [1]	290 [1]	285 [1]
15. Number of opted-out physicians (#).	0	0	0	0	0
16. Number of non-participating physicians (#).	0	0	0	0	0
17. Total payments for services provided by physicians paid through all payment methods ($).	34,266,756	35,751,371	37,467,787	39,063,498	39,478,160
18. Total payments for services provided by physicians paid through fee-for-service ($).	1,791,633	1,929,988	1,872,250	1,699,724	1,633,581

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
19. Number of services (#).	45,412	46,388	34,264	36,722	37,246
20. Total payments ($).	4,118,883	4,219,175	4,096,076	4,943,782	4,841,699
INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA					
21. Number of services (#).	95	113	118	116	91
22. Total payments ($).	9,051	6,230	6,883	9,750	9,245

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
23. Number of participating dentists (#).	not available	not available	not available	not available	not available
24. Number of services provided (#).	not available	not available	not available	not available	not available
25. Total payments ($).	not available	not available	not available	not available	not available

All data are subject to future revisions.

1. Estimate based on total active physicians for each fiscal year.

NUNAVUT

INTRODUCTION

The Department of Health and Social Services faces many unique challenges when providing for the health and well-being of Nunavummiut. The population of 31,906[1] is approximately 84 percent Inuit, and almost 61 percent of the population is under the age of 25 years (19,485 people).[2] The territory is made up of 25 communities located across three time zones and divided into three regions: the Baffin (or Qikiqtaaluk), the Kivalliq and the Kitikmeot.

The health status of Nunavummiut is significantly below the national average, and overall life expectancy trails the Canadian average by 10 years.[3] There are no roads or railways connecting Nunavut's communities, and air travel is the only means of travelling into, around and out of the territory. As the cost of airfare, agency nurses, medical technology, infrastructure and other related expenditures continues to rise, the Government of Nunavut continues to invest additional resources into public health; by making investments in health promotion and preventative care now, the high cost of primary health care in the future can be offset.[4]

The Government of Nunavut strives to incorporate Inuit societal values into program and policy development as well as into service design and delivery. The delivery of health services in Nunavut is based on a primary health care model. Nunavut's primary health care providers are family physicians, nurse practitioners, community health nurses, and pharmacists.

In 2011–2012, the territorial operations and maintenance budget for the Department of Health and Social Services was $323,880,000, after supplementary appropriations.[5] Over one quarter of the Department's total operational budget is spent on costs associated with medical travel and treatment provided in out-of-territory facilities. Due to the very low population density in this vast territory and limited health infrastructure (i.e., diagnostic services), access to a range of hospital and specialist services often requires that residents be sent out of the territory. An additional $34,861,000 was allocated to the Department for capital projects.[6]

1.0 PUBLIC ADMINISTRATION

1.1 Health Care Insurance Plan and Public Authority

The health care insurance plans of Nunavut, including physician and hospital services, are administered by the Department on a non-profit basis.

The *Medical Care Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) governs the entitlement to and payment of benefits for insured medical services. The *Hospital Insurance and Health and Social Services Administration Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) enables the establishment of hospital and other health services.

The Department has three regional offices that manage the delivery of health services at a regional level. Iqaluit operations are administered separately. The Department retained regional operations in each region of Nunavut to support front-line workers and community based delivery of a wide range of health and social services programs and services.

There were no legislative amendments in 2011–2012.

1.2 Reporting Relationship

Legislation governing the administration of health and social services in Nunavut was carried over from the Northwest Territories (as Nunavut statutes) pursuant to the *Nunavut Act*. The *Medical Care Act* governs who is covered by the Nunavut Health Care Plan and the payment of benefits for insured medical services. Section 23(1) of the *Medical Care Act* requires the Minister responsible for the Act to appoint a Director of Medical Insurance. The Director is responsible for the administration of the Act and regulations. Section 24

1. Statistics Canada, 2012 http://www12.statcan.ca/census-recensement/index-eng.cfm (2011 Statistics Canada Census as of October 24, 2012)
2. Statistics Canada, 2012 http://www12.statcan.ca/census-recensement/index-eng.cfm (2011 Statistics Canada Census as of October 24, 2012)
3. Government of Nunavut, 2011–2014 Business Plan
4. Government of Nunavut, 2011–2014 Business Plan
5. Government of Nunavut Supplementary Appropriations for the year ended March 31, 2012
6. Government of Nunavut Capital Estimates for the year ended March 31, 2012

requires the Director to submit an annual report on the operation of the Medical Care Plan (Nunavut Health Care Plan) to the Minister for tabling in the Legislative Assembly.

1.3 Audit of Accounts

The Auditor General of Canada is the auditor of the Government of Nunavut in accordance with section 30.1 of the *Financial Administration Act* (Nunavut, 1999). The Auditor General is required to conduct an annual audit of the transactions and consolidated financial statements of the Government of Nunavut. The most recent audited report was issued December 5, 2011.

2.0 COMPREHENSIVENESS

2.1 Insured Hospital Services

Insured hospital services are provided in Nunavut under the authority of the *Hospital Insurance and Health and Social Services Administration Act* and regulations, sections 2 to 4. No amendments were made to the Act or regulations in 2011–2012.

In 2011–2012 insured hospital services were delivered in 28 facilities across Nunavut, including one general hospital (Iqaluit), two regional health facilities (Rankin Inlet and Cambridge Bay), 22 community health centres, one public health facility (Iqaluit), and one family practice clinic (Iqaluit). There is also rehabilitative treatment available through the Timimut Ikajuksivik Centre, located in Iqaluit.

The Qikiqtani General Hospital (QGH) is currently the only acute care facility in Nunavut providing a range of in- and out-patient hospital services as defined by the *Canada Health Act*. QGH offers 24-hour emergency services, in-patient care (including obstetrics, pediatrics and palliative care), surgical services, laboratory services, diagnostic imaging, respiratory therapy, and health records and information.

As the two regional facilities in Rankin Inlet and Cambridge Bay are able to recruit additional physicians, they will also be able to offer a broader range of in-patient and out-patient services; currently Rankin Inlet is providing 24-hour care for in-patients, out-patients are provided care by on-call staff; and Cambridge Bay is providing daily clinic hours, and emergency care on-call 24-hours a day. There are also a limited number of birthing beds at both facilities. Public health services are provided at public health clinics located in Rankin Inlet, Cambridge Bay and Iqaluit.

Other community health centres provide public health services, out-patient services and urgent treatment services. The Department also operates a Family Practice Clinic in Iqaluit. The clinic, established in 2006 with funding from the Primary Health Care Transition Fund, has been successful in helping to reduce pressure on the emergency and out-patient departments of the QGH during working hours. The clinic provides a steady source of primary care appointments and programs, such as a Diabetes Clinic, and receives physician support via 2–3 physician days per month. At present, the clinic is staffed by three nurse practitioners.

The Department is responsible for authorizing, licensing, inspecting and supervising all health facilities and social services facilities in the territory. Insured in-patient hospital services include: accommodation and meals at the standard ward level; necessary nursing services; laboratory, radiological and other diagnostic procedures, together with the necessary interpretations; drugs, biological and related preparations prescribed by a physician and administered in hospital; routine surgical supplies; use of operating room, case-room and anaesthetic facilities; use of radiotherapy and physiotherapy services where available; psychiatric services provided under an approved program; services rendered by persons who are paid by the hospital. Out-patient services include: laboratory tests and x-rays, including interpretations, when requested by a physician and performed in an out-patient facility or in an approved hospital; hospital services in connection with most minor medical and surgical procedures; physiotherapy, occupational therapy, limited audiology and speech therapy services in an out-patient facility or in an approved hospital; and psychiatric and psychology services provided under an approved hospital program. The Department makes the determination to add insured services in its facilities based on the availability of appropriate resources, equipment and overall feasibility in accordance with financial guidelines set by the Department and with the approval of the Financial Management Board. No new services were added in 2011–2012 to the list of insured hospital services.

2.2 Insured Physician Services

The *Medical Care Act*, section 3(1), and Medical Care Regulations, section 3, provide for insured physician services in Nunavut. No amendments were made to the Act or regulations in 2011–2012. The *Nursing Act* allows for licensure of nurse practitioners in Nunavut; this permits nurses to deliver insured physician services in Nunavut.

Physicians must be in good standing with a College of Physicians and Surgeons (Canada) and be licensed to practice in Nunavut. The Government of Nunavut's Medical Registration Committee currently manages this process for Nunavut physicians. Nunavut recruits and hires its own family physicians, and accesses specialist services primarily from its main referral centres in Ottawa, Winnipeg, and Yellowknife. Recruitment of full-time family physicians has improved significantly and there are 26 family physician

positions funded through the Department, providing over 5,000 days of service annually across the territory.

There are a total of 26 full-time family physician positions in Nunavut (16 in the Baffin region; 7.5 positions in the Kivalliq region; 2.5 positions in the Kitikmeot region) There are also 1.5 general surgeons, 1 anaesthetist, and 1 pediatrician at the Qiqiktani General Hospital). Visiting specialists, general practitioners and locums, through arrangements made by each of the Department's three regions, also provide insured physician services. Physicians can make an election to collect fees other than those under the Medical Care Plan in accordance with section 12(2)(a) or (b) of the *Medical Care Act* by notifying the Director in writing. An election can be revoked the first day of the following month after a letter to that effect is delivered to the Director. In 2011–2012, no physicians provided written notice of this election.

All physicians practicing in Nunavut are under contract with the Department.

Insured physician services refer to all services rendered by medical practitioners that are medically required. Where insured services are unavailable in some places in Nunavut, the patient is referred to another jurisdiction to obtain the insured service. Nunavut has health service agreements with medical and treatment centres in Ottawa, Winnipeg, Churchill, Yellowknife and Edmonton. These are the out-of-territory sites to which Nunavut mainly refers its patients to access medical services not available within the territory.

The addition or deletion of insured physician services requires government approval. For this, the Director of Medical Insurance would become involved in negotiations with a collective group of physicians to discuss the service. Then the decision of the group would be presented to Cabinet for approval. No insured physician services were added or deleted in 2011–2012.

2.3 Insured Surgical-Dental Services

Dentists providing insured surgical-dental services under the Medical Care Insurance Plan of the territory must be licensed pursuant to the *Dental Professions Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999). Billing numbers are provided for billing the Plan regarding the provision of insured dental services.

Insured dental services are limited to those dental-surgical procedures scheduled in the regulations, requiring the unique capabilities of a hospital for their performance; for example, orthognathic surgery. Oral surgeons are brought to Nunavut on a regular basis, but on rare occasions, for medically complicated situations, patients are flown out of the territory.

The addition of new surgical-dental services to the list of insured services requires government approval. No new services were added to the list in 2011–2012.

2.4 Uninsured Hospital, Physician and Surgical-Dental Services

Services provided under the *Workers' Compensation Act* (NWT, 1988 and as duplicated for Nunavut by section 29 of the *Nunavut Act*, 1999) or other Acts of Canada, except the *Canada Health Act*, are excluded.

Services provided by physicians that are not insured include: yearly physicals; cosmetic surgery; services that are considered experimental; prescription drugs; physical examinations done at the request of a third party; optometric services; dental services other than specific procedures related to jaw injury or disease; the services of chiropractors, naturopaths, podiatrists, osteopaths and acupuncture treatments; and physiotherapy, speech therapy and psychology services received in a facility that is not an insured out-patient facility (hospital).

Services not covered in a hospital include: hospital charges above the standard ward rate for private or semi-private accommodation; services that are not medically required, such as cosmetic surgery; services that are considered experimental; ambulance charges (except inter-hospital transfers); dental services, other than specific procedures related to jaw injury or disease; and alcohol and drug rehabilitation, without prior approval.

In 2011–2012 the Qikiqtani General Hospital charged a $2,122 per diem rate for services provided for non-Canadian resident stays.

When residents are sent out of the territory for services, the Department relies on the policies and procedures guiding that particular jurisdiction when they provide services to Nunavut residents that could result in additional costs, only to the extent that these costs are covered by Nunavut's Medical Insurance Plan (see section 4.2 under Portability). Any query or complaint is handled on an individual basis with the jurisdiction involved.

The Department also administers the Non-Insured Health Benefits (NIHB) Program on behalf of Health Canada for Inuit and First Nations residents in Nunavut. NIHB covers a co-payment for medical travel, accommodations and meals at boarding homes (in Ottawa, Winnipeg, Churchill, Edmonton, Yellowknife and Iqaluit), prescription drugs, dental treatment, vision care, medical supplies and prostheses, and a number of other incidental services.

3.0 UNIVERSALITY

3.1 Eligibility

Eligibility for the Nunavut Health Care Plan is briefly defined under sections 3(1), (2), and (3) of the *Medical Care Act*. The Department also adheres to the Interprovincial Agreement on Eligibility and Portability, as well as internal guidelines. No amendments were made to the Act or regulations in 2011–2012.

Subject to these provisions, every Nunavut resident is eligible for and entitled to insured health services on uniform terms and conditions. A resident means a person lawfully entitled to be or to remain in Canada, who makes his or her home and is ordinarily present in Nunavut, but does not include a tourist, transient or visitor to Nunavut. Applications are accepted for health coverage, and supporting documentation is required to confirm residency. Eligible residents receive a health card with a unique health care number.

Registration requirements include a completed application form and supporting documentation. A health care card is issued to each resident. To streamline document processing, a staggered renewal process was initiated in Nunavut in 2006. No premiums exist. Coverage under the Nunavut Medical Insurance Plan is linked to verification of registration, although every effort is made to ensure registration occurs when a coverage issue arises for an eligible resident. For non-residents, a valid health care card from their home province/territory is required.

Coverage generally begins the first day of the third month after arrival in Nunavut, but first-day coverage is provided under a number of circumstances (e.g., newborns, whose mothers or fathers are eligible for coverage). Permanent residents (landed immigrants), returning Canadians, repatriated Canadians, returning permanent residents, and non-Canadians who have been issued an employment visa for a period of 12 months or more, are also granted first-day coverage.

Members of the Canadian Armed Forces and the Royal Canadian Mounted Police (RCMP)[7], and inmates of a federal penitentiary are not eligible for registration. These groups are granted first-day coverage under the Nunavut Health Care Plan upon discharge.

Pursuant to section 7 of the Interprovincial Agreement on Eligibility and Portability, persons in Nunavut who are temporarily absent from their home province or territory and who are not establishing residency in Nunavut remain covered by their home provincial or territorial health insurance plans for up to one year.

On March 31, 2012, 35,893 individuals were registered with the Nunavut Health Care Plan, up by 378 from the previous year. There are no formal provisions for Nunavut residents to opt out of the Nunavut Health Care Plan.

3.2 Other Categories of Individuals

Non-Canadian holders of employment visas of less than 12 months, foreign students with visas of less than 12 months, transient workers, and individuals holding a Minister's Permit (with one exception) are not eligible for coverage. When unique circumstances occur, assessments are done on an individual basis. This is consistent with section 15 of the Northwest Territories' Guidelines for Health Care Plan Registration, which was adopted by Nunavut in 1999.

4.0 PORTABILITY

4.1 Minimum Waiting Period

Consistent with section 3 of the Interprovincial Agreement on Eligibility and Portability, the waiting period before coverage begins for individuals moving within Canada is three months, or the first day of the third month following the establishment of residency in a new province or territory, or the first day of the third month when an individual, who has been temporarily absent from his or her home province, decides to take up permanent residency in Nunavut.

4.2 Coverage During Temporary Absences in Canada

The *Medical Care Act*, section 4(2), prescribes the benefits payable where insured medical services are provided outside Nunavut, but within Canada. The *Hospital Insurance and Health and Social Services Administration Act*, sections 5(d) and 28(1)(j)(o), provide the authority for the Minister to enter into agreements with other jurisdictions to provide health services to Nunavut residents and the terms and conditions of payment. No legislative or regulatory changes were made in 2011–2012 with respect to coverage outside Nunavut.

Students studying outside Nunavut must notify the Department and provide proof of enrolment to ensure continuing coverage. Requests for extensions must be

7. On June 29, 2012, as a result of the federal *Jobs, Growth and Long-term Prosperity Act*, the Canada Health Act was amended to allow members of the RCMP to be eligible for coverage under provincial and territorial health plans. At the time this report was compiled, federal, provincial and territorial governments were in consultation on the changes in provincial and territorial health legislation that would be required for members of the RCMP to be considered insured persons under provincial and territorial health insurance plans.

renewed yearly and are subject to approval by the Director. Temporary absences for work, vacation or other reasons for up to one year are approved by the Director upon receipt of a written request from the insured person. The Director may approve absences in excess of 12 continuous months upon receiving a written request from the insured individual.

The provisions regarding coverage during temporary absences in Canada fully comply with the terms and conditions of the Interprovincial Agreement on Eligibility and Portability, as of January 1, 2001.

Nunavut participates in physician and hospital reciprocal billing. As well, special bilateral agreements are in place with Ontario, Manitoba, Alberta and the Northwest Territories. The Hospital Reciprocal Billing Agreements provide payment of in- and out-patient hospital services to eligible Nunavut residents receiving insured services outside the territory. High-cost procedure rates, newborn rates and out-patient rates are based on those established by the Interprovincial Health Insurance Agreements Coordinating Committee. A special agreement exists between the Northwest Territories and Nunavut, which, based on a block-funding approach, enables the Stanton Hospital in Yellowknife to provide services to Nunavut residents in the hospital and through visiting specialist services in the Kitikmeot area (western part of the territory).

The Physician Reciprocal Billing Agreements provide payment of insured physician services on behalf of eligible Nunavut residents receiving insured services outside the territory. Payment is made to the host province at the rates established by that province.

4.3 Coverage During Temporary Absences Outside Canada

The *Medical Care Act*, section 4(3), prescribes the benefits payable where insured medical services are provided outside Canada. The *Hospital Insurance and Health and Social Services Administration Act*, section 28(1)(j)(o), provides the authority for the Minister to set the terms and conditions of payment for services provided to Nunavut residents outside Canada. Individuals are granted coverage for up to one year if they are temporarily out of the country for any reason, although they must give prior notice in writing. For services provided to residents who have been referred out of the country for highly specialized procedures unavailable in Nunavut and Canada, Nunavut will pay the full cost. For non-referred or non-emergency services, the payment for hospital services is $2,122 per day and $270 for out-patient care. These rates increased by $76 and $10 respectively from 2011–2012.

Insured physician services provided to eligible residents temporarily outside the country are paid at rates equivalent to those paid had that service been provided in the territory. Reimbursement is made to the insured person or directly to the provider of the insured service.

4.4 Prior Approval Requirement

Prior approval is required for elective services provided in private facilities in Canada or in any facility outside the country.

5.0 ACCESSIBILITY

5.1 Access to Insured Health Services

The *Medical Care Act*, section 14, prohibits extra billing by physicians unless the medical practitioner has made an election that is still in effect. Access to insured services is provided on uniform terms and conditions. To break down the barrier posed by distance and cost of travel, the Government of Nunavut provides medical travel assistance. Interpretation services in the Inuit language are also provided to patients in any health care setting.

The Qikiqtani General Hospital in Iqaluit is the only operating acute care hospital facility in Nunavut. The hospital has a total of 35 beds available for acute, rehabilitative, palliative and chronic care services; currently 20 general purpose beds are in use due to capacity and need. There are also four birthing rooms and six day surgery beds. The facility provides in-patient, out-patient and 24-hour emergency services. On-site physicians provide emergency services on rotation. Medical services provided include an ambulatory care/out-patient clinic, limited intensive care services, and general medical, maternity and palliative care. Surgical services provided include minor orthopaedics, gynaecology, paediatrics, general abdominal, emergency trauma and ENT/otolaryngology. Patients requiring specialized surgeries are sent to other jurisdictions. Diagnostic services include radiology, laboratory and electrocardiogram. Rehabilitative services are limited to Iqaluit. Although nursing and other health professionals were not at full capacity, all essential acute, public, dental and mental health services were provided in 2011–2012.

Outside of Iqaluit, out-patient and 24-hour emergency nursing services are provided by local health centres in Nunavut's 24 other communities. Telehealth services are available in all 25 communities in Nunavut. The long-term goal is to integrate Telehealth into the primary care delivery system, enabling residents of Nunavut greater access to a broader range of service options, and allowing service providers and communities to use existing resources more effectively.

Nunavut has agreements in place with a number of out-of-territory regional health authorities and specific facilities to provide medical specialists and other visiting health practitioner services. The following specialist services were provided in Nunavut during 2011–2012 under the visiting specialists program: ophthalmology; orthopaedics; internal medicine; otolaryngology; neurology; rheumatology; dermatology; paediatrics; obstetrics; physiotherapy; occupational therapy; psychiatry; oral surgery and allergist. Visiting specialist clinics are held depending on demand and availability of specialists.

Nunavut's Telehealth network, linking all 25 communities, allows for the delivery of a broad range of services over distances including specialist consultation services such as dermatology, psychiatry and internal medicine; rehabilitation services; regularly scheduled counselling sessions; family visitation; and continuing medical education.

For services and equipment unavailable in Nunavut, patients are referred to other jurisdictions.

5.2 Physician Compensation

All full-time physicians in Nunavut work under contract with the Department. The terms of the contracts are set by the Department. Visiting consultants are either paid on a per-diem basis or through fee-for-service.

5.3 Payments to Hospitals

Funding for the Qiqiktani General Hospital, regional health facilities and community health centres is provided through the Government of Nunavut's budget process.

6.0 RECOGNITION GIVEN TO FEDERAL TRANSFERS

Nunavummiut are aware of ongoing federal contributions through press releases and media coverage. The Government of Nunavut has also recognized the federal contribution provided through the Canada Health Transfer in various published documents. For fiscal year 2011–2012, they included:

- 2011–2012 Budget Address; and
- 2011–2014 Government of Nunavut Business Plan.

REGISTERED PERSONS					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
1. Number as of March 31st (#).	31,412	32,207	33,540	35,515 [8]	35,893

INSURED HOSPITAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
Public Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
2. Number (#).	28	28	28	28	28
3. Payments for insured health services ($).	not available	not available	not available	not available	not available
Private For-Profit Facilities	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
4. Number of private for-profit facilities providing insured health services (#).	0	0	0	0	0
5. Payments to private for-profit facilities for insured health services ($).	0	0	0	0	0

INSURED HOSPITAL SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
6. Total number of claims, in-patient (#).	2,255	2,841	2,890	2,924	3,406
7. Total payments, in-patient ($).	19,001,348	26,481,948	30,013,566	28,527,577	38,486,274
8. Total number of claims, out-patient (#).	15,192	19,579	18,270	18,352	22,725
9. Total payments, out-patient ($).	3,659,654	6,631,568	5,985,808	6,318,885	8,975,802
INSURED HOSPITAL SERVICES PROVIDED OUTSIDE CANADA					
10. Total number of claims, in-patient (#).	0	0	0	0	0
11. Total payments, in-patient ($).	0	0	0	0	0
12. Total number of claims, out-patient (#).	0	0	0	0	0
13. Total payments, out-patient ($).	0	0	0	0	0

8. The difference in the number of registered Nunavut residents and those covered under the Nunavut Health Care Plan is due to delays in the reconciliation of data on residents who have left the territory.

INSURED PHYSICIAN SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
14. Number of participating physicians (#).	156	218	225	225	375
15. Number of opted-out physicians (#).	0	0	0	0	0
16. Number of non-participating physicians (#).	0	0	0	0	0
17. Total payments for services provided by physicians paid through all payment methods ($).	not available	not available	not available	not available	not available
18. Total payments for services provided by physicians paid through fee-for-service ($).[9]	2,158,549	1,021,829	300,980	312,786	334,539

INSURED PHYSICIAN SERVICES PROVIDED TO RESIDENTS IN ANOTHER PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
19. Number of services (#).	53,022	65,171	72,065	73,564	75,108
20. Total payments ($).	3,845,570	4,768,388	5,585,067	5,901,962	6,393,341
INSURED PHYSICIAN SERVICES PROVIDED OUTSIDE CANADA					
21. Number of services (#).	15	36	17	53	22
22. Total payments ($).	796	2,458	4,848	1,575	963

INSURED SURGICAL-DENTAL SERVICES WITHIN OWN PROVINCE OR TERRITORY					
	2007–2008	2008–2009	2009–2010	2010–2011	2011–2012
23. Number of participating dentists (#).	not available	not available	not available	not available	not available
24. Number of services provided (#).	not available	not available	not available	not available	not available
25. Total payments ($).	not available	not available	not available	not available	not available

9. Typically, Nunavut does not pay its physicians through fee-for-service. Instead, the majority of physicians are compensated through contracted salaries. Statistical information on salaried physicians is reported via the shadow billing process.

ANNEX A

CANADA HEALTH ACT AND EXTRA-BILLING AND USER CHARGES INFORMATION REGULATIONS

This annex provides the reader with an office consolidation of the *Canada Health Act* and the Extra-billing and User Charges Information Regulations. An "office consolidation" is a rendering of the original Act, which includes any amendments that have been made since the Act's passage. The only regulations in force under the Act are the Extra-billing and User Charges Infor-mation Regulations. These regulations require the provinces and territories to provide estimates of extra-billing and user charges prior to the beginning of each fiscal year so that appropriate penalties can be levied, as well as financial statements showing the amounts actually charged so that reconciliations with any estimated charges can be made. These regulations are also presented in an office consolidation format. This unofficial consolidation is current to July 8, 2012. It is provided for the convenience of the reader only. For the official text of the *Canada Health Act*, please contact Justice Canada.

CANADA

CONSOLIDATION

CODIFICATION

Canada Health Act

Loi canadienne sur la santé

R.S.C., 1985, c. C-6

L.R.C., 1985, ch. C-6

Current to July 8, 2012

Last amended on June 29, 2012

À jour au 8 juillet 2012

Dernière modification le 29 juin 2012

Published by the Minister of Justice at the following address:
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Publié par le ministre de la Justice à l'adresse suivante :
http://lois-laws.justice.gc.ca

OFFICIAL STATUS OF CONSOLIDATIONS

Subsections 31(1) and (2) of the *Legislation Revision and Consolidation Act*, in force on June 1, 2009, provide as follows:

Published consolidation is evidence

31. (1) Every copy of a consolidated statute or consolidated regulation published by the Minister under this Act in either print or electronic form is evidence of that statute or regulation and of its contents and every copy purporting to be published by the Minister is deemed to be so published, unless the contrary is shown.

Inconsistencies in Acts

(2) In the event of an inconsistency between a consolidated statute published by the Minister under this Act and the original statute or a subsequent amendment as certified by the Clerk of the Parliaments under the *Publication of Statutes Act*, the original statute or amendment prevails to the extent of the inconsistency.

NOTE

This consolidation is current to July 8, 2012. The last amendments came into force on June 29, 2012. Any amendments that were not in force as of July 8, 2012 are set out at the end of this document under the heading "Amendments Not in Force".

CARACTÈRE OFFICIEL DES CODIFICATIONS

Les paragraphes 31(1) et (2) de la *Loi sur la révision et la codification des textes législatifs*, en vigueur le 1er juin 2009, prévoient ce qui suit :

Codifications comme élément de preuve

31. (1) Tout exemplaire d'une loi codifiée ou d'un règlement codifié, publié par le ministre en vertu de la présente loi sur support papier ou sur support électronique, fait foi de cette loi ou de ce règlement et de son contenu. Tout exemplaire donné comme publié par le ministre est réputé avoir été ainsi publié, sauf preuve contraire.

Incompatibilité — lois

(2) Les dispositions de la loi d'origine avec ses modifications subséquentes par le greffier des Parlements en vertu de la *Loi sur la publication des lois* l'emportent sur les dispositions incompatibles de la loi codifiée publiée par le ministre en vertu de la présente loi.

NOTE

Cette codification est à jour au 8 juillet 2012. Les dernières modifications sont entrées en vigueur le 29 juin 2012. Toutes modifications qui n'étaient pas en vigueur au 8 juillet 2012 sont énoncées à la fin de ce document sous le titre « Modifications non en vigueur ».

R.S.C., 1985, c. C-6

L.R.C., 1985, ch. C-6

An Act relating to cash contributions by Canada and relating to criteria and conditions in respect of insured health services and extended health care services

Loi concernant les contributions pécuniaires du Canada ainsi que les principes et conditions applicables aux services de santé assurés et aux services complémentaires de santé

Preamble

WHEREAS the Parliament of Canada recognizes:

—that it is not the intention of the Government of Canada that any of the powers, rights, privileges or authorities vested in Canada or the provinces under the provisions of the *Constitution Act, 1867*, or any amendments thereto, or otherwise, be by reason of this Act abrogated or derogated from or in any way impaired;

—that Canadians, through their system of insured health services, have made outstanding progress in treating sickness and alleviating the consequences of disease and disability among all income groups;

—that Canadians can achieve further improvements in their well-being through combining individual lifestyles that emphasize fitness, prevention of disease and health promotion with collective action against the social, environmental and occupational causes of disease, and that they desire a system of health services that will promote physical and mental health and protection against disease;

—that future improvements in health will require the cooperative partnership of governments, health professionals, voluntary organizations and individual Canadians;

—that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians;

Préambule

Considérant que le Parlement du Canada reconnaît :

que le gouvernement du Canada n'entend pas par la présente loi abroger les pouvoirs, droits, privilèges ou autorités dévolus au Canada ou aux provinces sous le régime de la *Loi constitutionnelle de 1867* et de ses modifications ou à tout autre titre, ni leur déroger ou porter atteinte,

que les Canadiens ont fait des progrès remarquables, grâce à leur système de services de santé assurés, dans le traitement des maladies et le soulagement des affections et déficiences parmi toutes les catégories socio-économiques,

que les Canadiens peuvent encore améliorer leur bien-être en joignant à un mode de vie individuel axé sur la condition physique, la prévention des maladies et la promotion de la santé, une action collective contre les causes sociales, environnementales ou industrielles des maladies et qu'ils désirent un système de services de santé qui favorise la santé physique et mentale et la protection contre les maladies,

que les améliorations futures dans le domaine de la santé nécessiteront la coopération des gouvernements, des professionnels de la santé, des organismes bénévoles et des citoyens canadiens,

que l'accès continu à des soins de santé de qualité, sans obstacle financier ou autre, sera déterminant pour la conservation et l'amélioration de la santé et du bien-être des Canadiens;

AND WHEREAS the Parliament of Canada wishes to encourage the development of health services throughout Canada by assisting the provinces in meeting the costs thereof;

considérant en outre que le Parlement du Canada souhaite favoriser le développement des services de santé dans tout le pays en aidant les provinces à en supporter le coût,

NOW, THEREFORE, Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

Sa Majesté, sur l'avis et avec le consentement du Sénat et de la Chambre des communes du Canada, édicte :

SHORT TITLE

Short title

1. This Act may be cited as the *Canada Health Act*.

1984, c. 6, s. 1.

TITRE ABRÉGÉ

Titre abrégé

1. *Loi canadienne sur la santé.*

1984, ch. 6, art. 1.

INTERPRETATION

Definitions

2. In this Act,

"Act of 1977" [Repealed, 1995, c. 17, s. 34]

"cash contribution" « *contribution pécuniaire* »

"cash contribution" means the cash contribution in respect of the Canada Health Transfer that may be provided to a province under sections 24.2 and 24.21 of the *Federal-Provincial Fiscal Arrangements Act*;

"contribution" [Repealed, 1995, c. 17, s. 34]

"dentist" « *dentiste* »

"dentist" means a person lawfully entitled to practise dentistry in the place in which the practice is carried on by that person;

"extended health care services" « *services complémentaires de santé* »

"extended health care services" means the following services, as more particularly defined in the regulations, provided for residents of a province, namely,

(*a*) nursing home intermediate care service,

(*b*) adult residential care service,

(*c*) home care service, and

(*d*) ambulatory health care service;

"extra-billing" « *surfacturation* »

"extra-billing" means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province;

"health care insurance plan" « *régime d'assurance-santé* »

"health care insurance plan" means, in relation to a province, a plan or plans established by the law of the province to provide for insured health services;

DÉFINITIONS

Définitions

2. Les définitions qui suivent s'appliquent à la présente loi.

« assuré » *"insured person"*

« assuré » Habitant d'une province, à l'exception :

a) des membres des Forces canadiennes;

b) [Abrogé, 2012, ch. 19, art. 377]

c) des personnes purgeant une peine d'emprisonnement dans un pénitencier, au sens de la Partie I de la *Loi sur le système correctionnel et la mise en liberté sous condition*;

d) des habitants de la province qui s'y trouvent depuis une période de temps inférieure au délai minimal de résidence ou de carence d'au plus trois mois imposé aux habitants par la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés.

« contribution » [Abrogée, 1995, ch. 17, art. 34]

« contribution pécuniaire » *"cash contribution"*

« contribution pécuniaire » La contribution au titre du Transfert canadien en matière de santé qui peut être versée à une province au titre des articles 24.2 et 24.21 de la *Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces*.

« dentiste » *"dentist"*

« dentiste » Personne légalement autorisée à exercer la médecine dentaire au lieu où elle se livre à cet exercice.

« frais modérateurs » *"user charge"*

« frais modérateurs » Frais d'un service de santé assuré autorisés ou permis par un régime provincial d'assurance-santé mais non payables,

"health care practitioner" *« professionnel de la santé »*

"health care practitioner" means a person lawfully entitled under the law of a province to provide health services in the place in which the services are provided by that person;

"hospital" *« hôpital »*

"hospital" includes any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care, but does not include

(*a*) a hospital or institution primarily for the mentally disordered, or

(*b*) a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children;

"hospital services" *« services hospitaliers »*

"hospital services" means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,

(*a*) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,

(*b*) nursing service,

(*c*) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,

(*d*) drugs, biologicals and related preparations when administered in the hospital,

(*e*) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,

(*f*) medical and surgical equipment and supplies,

(*g*) use of radiotherapy facilities,

(*h*) use of physiotherapy facilities, and

(*i*) services provided by persons who receive remuneration therefor from the hospital,

but does not include services that are excluded by the regulations;

"insured health services" *« services de santé assurés »*

"insured health services" means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province, other than amounts payable on account of extra charges or on account of charges for services not medically required, that are provided for under provincial health insurance plans;

soit directement soit indirectement, au titre d'un régime provincial d'assurance-santé, à l'exception des frais imposés par surfacturation.

« habitant » *"resident"*

« habitant » Personne domiciliée et résidant habituellement dans une province et légalement autorisée à être ou à rester au Canada, à l'exception d'une personne faisant du tourisme, de passage ou en visite dans la province.

« hôpital » *"hospital"*

« hôpital » Sont compris parmi les hôpitaux tout ou partie des établissements où sont fournis des soins hospitaliers, notamment aux personnes souffrant de maladie aiguë ou chronique ainsi qu'en matière de réadaptation, à l'exception :

a) des hôpitaux ou institutions destinés principalement aux personnes souffrant de troubles mentaux;

b) de tout ou partie des établissements où sont fournis des soins intermédiaires en maison de repos ou des soins en établissement pour adultes ou des soins comparables pour les enfants.

« loi de 1977 » [Abrogée, 1995, ch. 17, art. 34]

« médecin » *"medical practitioner"*

« médecin » Personne légalement autorisée à exercer la médecine au lieu où elle se livre à cet exercice.

« ministre » *"Minister"*

« ministre » Le ministre de la Santé.

« professionnel de la santé » *"health care practitioner"*

« professionnel de la santé » Personne légalement autorisée en vertu de la loi d'une province à fournir des services de santé au lieu où elle les fournit.

« régime d'assurance-santé » *"health care insurance plan"*

« régime d'assurance-santé » Le régime ou les régimes constitués par la loi d'une province en vue de la prestation de services de santé assurés.

« services complémentaires de santé » *"extended health care services"*

« services complémentaires de santé » Les services définis dans les règlements et offerts aux habitants d'une province, à savoir :

a) les soins intermédiaires en maison de repos;

b) les soins en établissement pour adultes;

c) les soins à domicile;

d) les soins ambulatoires.

ture of a province that relates to workers' or workmen's compensation;

"insured person" « *assuré* »

"insured person" means, in relation to a province, a resident of the province other than

(*a*) a member of the Canadian Forces,

(*b*) [Repealed, 2012, c. 19, s. 377]

(*c*) a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or

(*d*) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services;

"medical practitioner" « *médecin* »

"medical practitioner" means a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person;

"Minister" « *ministre* »

"Minister" means the Minister of Health;

"physician services" « *services médicaux* »

"physician services" means any medically required services rendered by medical practitioners;

"resident" « *habitant* »

"resident" means, in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province;

"surgical-dental services" « *services de chirurgie dentaire* »

"surgical-dental services" means any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures;

"user charge" « *frais modérateurs* »

"user charge" means any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing.

R.S., 1985, c. C-6, s. 2; 1992, c. 20, s. 216(F); 1995, c. 17, s. 34; 1996, c. 8, s. 32; 1999, c. 26, s. 11; 2012, c. 19, ss. 377, 407.

« services de chirurgie dentaire » "*surgical dental services*"

«services de chirurgie dentaire» Actes de chirurgie dentaire nécessaires sur le plan médical ou dentaire, accomplis par un dentiste dans un hôpital, et qui ne peuvent être accomplis convenablement qu'en un tel établissement.

« services de santé assurés » "*insured health services*"

«services de santé assurés» Services hospitaliers, médicaux ou de chirurgie dentaire fournis aux assurés, à l'exception des services de santé auxquels une personne a droit ou est admissible en vertu d'une autre loi fédérale ou d'une loi provinciale relative aux accidents du travail.

« services hospitaliers » "*hospital services*"

«services hospitaliers» Services fournis dans un hôpital aux malades hospitalisés ou externes, si ces services sont médicalement nécessaires pour le maintien de la santé, la prévention des maladies ou le diagnostic ou le traitement des blessures, maladies ou invalidités, à savoir :

a) l'hébergement et la fourniture des repas en salle commune ou, si médicalement nécessaire, en chambre privée ou semi-privée;

b) les services infirmiers;

c) les actes de laboratoires, de radiologie ou autres actes de diagnostic, ainsi que les interprétations nécessaires;

d) les produits pharmaceutiques, substances biologiques et préparations connexes administrés à l'hôpital;

e) l'usage des salles d'opération, des salles d'accouchement et des installations d'anesthésie, ainsi que le matériel et les fournitures nécessaires;

f) le matériel et les fournitures médicaux et chirurgicaux;

g) l'usage des installations de radiothérapie;

h) l'usage des installations de physiothérapie;

i) les services fournis par les personnes rémunérées à cet effet par l'hôpital.

Ne sont pas compris parmi les services hospitaliers les services exclus par les règlements.

« services médicaux » "*physician services*"

«services médicaux» Services médicalement nécessaires fournis par un médecin.

« surfacturation » "*extra billing*"

«surfacturation» Facturation de la prestation à un assuré par un médecin ou un dentiste d'un

service de santé assuré, en excédent par rapport au montant payé ou à payer pour la prestation de ce service au titre du régime provincial d'assurance-santé.

L.R. (1985), ch. C-6, art. 2; 1992, ch. 20, art. 216(F); 1995, ch. 17, art. 34; 1996, ch. 8, art. 32; 1999, ch. 26, art. 11; 2012, ch. 19, art. 377 et 407.

CANADIAN HEALTH CARE POLICY

POLITIQUE CANADIENNE DE LA SANTÉ

Primary objective of Canadian health care policy

3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

1984, c. 6, s. 3.

Objectif premier

3. La politique canadienne de la santé a pour premier objectif de protéger, de favoriser et d'améliorer le bien-être physique et mental des habitants du Canada et de faciliter un accès satisfaisant aux services de santé, sans obstacles d'ordre financier ou autre.

1984, ch. 6, art. 3.

PURPOSE

RAISON D'ÊTRE

Purpose of this Act

4. The purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

R.S., 1985, c. C-6, s. 4; 1995, c. 17, s. 35.

Raison d'être de la présente loi

4. La présente loi a pour raison d'être d'établir les conditions d'octroi et de versement d'une pleine contribution pécuniaire pour les services de santé assurés et les services complémentaires de santé fournis en vertu de la loi d'une province.

L.R. (1985), ch. C-6, art. 4; 1995, ch. 17, art. 35.

CASH CONTRIBUTION

CONTRIBUTION PÉCUNIAIRE

Cash contribution

5. Subject to this Act, as part of the Canada Health Transfer, a full cash contribution is payable by Canada to each province for each fiscal year.

R.S., 1985, c. C-6, s. 5; 1995, c. 17, s. 36; 2012, c. 19, s. 408.

Contribution pécuniaire

5. Sous réserve des autres dispositions de la présente loi, le Canada verse à chaque province, pour chaque exercice, une pleine contribution pécuniaire à titre d'élément du Transfert canadien en matière de santé (ci-après, «Transfert»).

L.R. (1985), ch. C-6, art. 5; 1995, ch. 17, art. 36; 2012, ch. 19, art. 408.

6. [Repealed, 1995, c. 17, s. 36]

6. [Abrogé, 1995, ch. 17, art. 36]

PROGRAM CRITERIA

CONDITIONS D'OCTROI

Program criteria

7. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

(*a*) public administration;

(*b*) comprehensiveness;

(*c*) universality;

(*d*) portability; and

Règle générale

7. Le versement à une province, pour un exercice, de la pleine contribution pécuniaire visée à l'article 5 est assujetti à l'obligation pour le régime d'assurance-santé de satisfaire, pendant tout cet exercice, aux conditions d'octroi énumérées aux articles 8 à 12 quant à:

a) la gestion publique;

b) l'intégralité;

c) l'universalité;

d) la transférabilité;

(*e*) accessibility.

1984, c. 6, s. 7.

e) l'accessibilité.

1984, ch. 6, art. 7.

Public administration

8. (1) In order to satisfy the criterion respecting public administration,

(*a*) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;

(*b*) the public authority must be responsible to the provincial government for that administration and operation; and

(*c*) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.

Gestion publique

8. (1) La condition de gestion publique suppose que :

a) le régime provincial d'assurance-santé soit géré sans but lucratif par une autorité publique nommée ou désignée par le gouvernement de la province;

b) l'autorité publique soit responsable devant le gouvernement provincial de cette gestion;

c) l'autorité publique soit assujettie à la vérification de ses comptes et de ses opérations financières par l'autorité chargée par la loi de la vérification des comptes de la province.

Designation of agency permitted

(2) The criterion respecting public administration is not contravened by reason only that the public authority referred to in subsection (1) has the power to designate any agency

(*a*) to receive on its behalf any amounts payable under the provincial health care insurance plan; or

(*b*) to carry out on its behalf any responsibility in connection with the receipt or payment of accounts rendered for insured health services, if it is a condition of the designation that all those accounts are subject to assessment and approval by the public authority and that the public authority shall determine the amounts to be paid in respect thereof.

1984, c. 6, s. 8.

Désignation d'un mandataire

(2) La condition de gestion publique n'est pas enfreinte du seul fait que l'autorité publique visée au paragraphe (1) a le pouvoir de désigner un mandataire chargé :

a) soit de recevoir en son nom les montants payables au titre du régime provincial d'assurance-santé;

b) soit d'exercer en son nom les attributions liées à la réception ou au règlement des comptes remis pour prestation de services de santé assurés si la désignation est assujettie à la vérification et à l'approbation par l'autorité publique des comptes ainsi remis et à la détermination par celle-ci des montants à payer à cet égard.

1984, ch. 6, art. 8.

Comprehensiveness

9. In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

1984, c. 6, s. 9.

Intégralité

9. La condition d'intégralité suppose qu'au titre du régime provincial d'assurance-santé, tous les services de santé assurés fournis par les hôpitaux, les médecins ou les dentistes soient assurés, et lorsque la loi de la province le permet, les services semblables ou additionnels fournis par les autres professionnels de la santé.

1984, ch. 6, art. 9.

Universality

10. In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the in-

Universalité

10. La condition d'universalité suppose qu'au titre du régime provincial d'assurance-santé, cent pour cent des assurés de la province ait droit aux services de santé assurés prévus par celui-ci, selon des modalités uniformes.

1984, ch. 6, art. 10.

sured health services provided for by the plan on uniform terms and conditions.

1984, c. 6, s. 10.

Portability

11. (1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province

(*a*) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services;

(*b*) must provide for and be administered and operated so as to provide for the payment of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that

(i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or

(ii) where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors; and

(*c*) must provide for and be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reason of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.

Requirement for consent for elective insured health services permitted

(2) The criterion respecting portability is not contravened by a requirement of a provincial health care insurance plan that the prior consent of the public authority that administers and operates the plan must be obtained for elective in-

Transférabilité

11. (1) La condition de transférabilité suppose que le régime provincial d'assurance-santé:

a) n'impose pas de délai minimal de résidence ou de carence supérieur à trois mois aux habitants de la province pour qu'ils soient admissibles ou aient droit aux services de santé assurés;

b) prévoie et que ses modalités d'application assurent le paiement des montants pour le coût des services de santé assurés fournis à des assurés temporairement absents de la province:

(i) si ces services sont fournis au Canada, selon le taux approuvé par le régime d'assurance-santé de la province où ils sont fournis, sauf accord de répartition différente du coût entre les provinces concernées,

(ii) s'il sont fournis à l'étranger, selon le montant qu'aurait versé la province pour des services semblables fournis dans la province, compte tenu, s'il s'agit de services hospitaliers, de l'importance de l'hôpital, de la qualité des services et des autres facteurs utiles;

c) prévoie et que ses modalités d'application assurent la prise en charge, pendant le délai minimal de résidence ou de carence imposé par le régime d'assurance-santé d'une autre province, du coût des services de santé assurés fournis aux personnes qui ne sont plus assurées du fait qu'elles habitent cette province, dans les mêmes conditions que si elles habitaient encore leur province d'origine.

Consentement préalable à la prestation des services de santé assurés facultatifs

(2) La condition de transférabilité n'est pas enfreinte du fait qu'il faut, aux termes du régime d'assurance-santé d'une province, le consentement préalable de l'autorité publique qui le gère pour la prestation de services de

sured health services provided to a resident of the province while temporarily absent from the province if the services in question were available on a substantially similar basis in the province.

santé assurés facultatifs à un habitant temporairement absent de la province, si ces services y sont offerts selon des modalités sensiblement comparables.

Definition of "elective insured health services"

(3) For the purpose of subsection (2), "elective insured health services" means insured health services other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay.

(3) Pour l'application du paragraphe (2), « services de santé assurés facultatifs » s'entend des services de santé assurés, à l'exception de ceux qui sont fournis d'urgence ou dans d'autres circonstances où des soins médicaux sont requis sans délai.

Définition de « services de santé assurés facultatifs »

1984, c. 6, s. 11.

1984, ch. 6, art. 11.

Accessibility

12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

12. (1) La condition d'accessibilité suppose que le régime provincial d'assurance-santé :

Accessibilité

(*a*) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;

a) offre les services de santé assurés selon des modalités uniformes et ne fasse pas obstacle, directement ou indirectement, et notamment par facturation aux assurés, à un accès satisfaisant par eux à ces services;

(*b*) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;

b) prévoie la prise en charge des services de santé assurés selon un tarif ou autre mode de paiement autorisé par la loi de la province;

(*c*) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and

c) prévoie une rémunération raisonnable de tous les services de santé assurés fournis par les médecins ou les dentistes;

(*d*) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

d) prévoie le versement de montants aux hôpitaux, y compris les hôpitaux que possède ou gère le Canada, à l'égard du coût des services de santé assurés.

Reasonable compensation

(2) In respect of any province in which extra-billing is not permitted, paragraph (1)(*c*) shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides

(2) Pour toute province où la surfacturation n'est pas permise, il est réputé être satisfait à l'alinéa (1)*c*) si la province a choisi de conclure un accord et a effectivement conclu un accord avec ses médecins et dentistes prévoyant :

Rémunération raisonnable

(*a*) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners or dentists in the province;

a) la tenue de négociations sur la rémunération des services de santé assurés entre la province et les organisations provinciales représentant les médecins ou dentistes qui exercent dans la province;

(*b*) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred

b) le règlement des différends concernant la rémunération par, au choix des organisations provinciales compétentes visées à l'alinéa *a*), soit la conciliation soit l'arbitrage obligatoire par un groupe représentant également les or-

to in paragraph (*a*), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and

(*c*) that a decision of a panel referred to in paragraph (*b*) may not be altered except by an Act of the legislature of the province.

1984, c. 6, s. 12.

ganisations provinciales et la province et ayant un président indépendant;

c) l'impossibilité de modifier la décision du groupe visé à l'alinéa *b*), sauf par une loi de la province.

1984, ch. 6, art. 12.

CONDITIONS FOR CASH CONTRIBUTION

Conditions

13. In order that a province may qualify for a full cash contribution referred to in section 5, the government of the province

(*a*) shall, at the times and in the manner prescribed by the regulations, provide the Minister with such information, of a type prescribed by the regulations, as the Minister may reasonably require for the purposes of this Act; and

(*b*) shall give recognition to the Canada Health Transfer in any public documents, or in any advertising or promotional material, relating to insured health services and extended health care services in the province.

R.S., 1985, c. C-6, s. 13; 1995, c. 17, s. 37; 2012, c. 19, s. 409(E).

CONTRIBUTION PÉCUNIAIRE ASSUJETTIE À DES CONDITIONS

Obligations de la province

13. Le versement à une province de la pleine contribution pécuniaire visée à l'article 5 est assujetti à l'obligation pour le gouvernement de la province :

a) de communiquer au ministre, selon les modalités de temps et autres prévues par les règlements, les renseignements du genre prévu aux règlements, dont celui-ci peut normalement avoir besoin pour l'application de la présente loi;

b) de faire état du Transfert dans tout document public ou toute publicité sur les services de santé assurés et les services complémentaires de santé dans la province.

L.R. (1985), ch. C-6, art. 13; 1995, ch. 17, art. 37; 2012, ch. 19, art. 409(A).

DEFAULTS

Referral to Governor in Council

14. (1) Subject to subsection (3), where the Minister, after consultation in accordance with subsection (2) with the minister responsible for health care in a province, is of the opinion that

(*a*) the health care insurance plan of the province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12, or

(*b*) the province has failed to comply with any condition set out in section 13,

and the province has not given an undertaking satisfactory to the Minister to remedy the default within a period that the Minister considers reasonable, the Minister shall refer the matter to the Governor in Council.

Consultation process

(2) Before referring a matter to the Governor in Council under subsection (1) in respect of a province, the Minister shall

MANQUEMENTS

Renvoi au gouverneur en conseil

14. (1) Sous réserve du paragraphe (3), dans le cas où il estime, après avoir consulté conformément au paragraphe (2) son homologue chargé de la santé dans une province :

a) soit que le régime d'assurance-santé de la province ne satisfait pas ou plus aux conditions visées aux articles 8 à 12;

b) soit que la province ne s'est pas conformée aux conditions visées à l'article 13,

et que celle-ci ne s'est pas engagée de façon satisfaisante à remédier à la situation dans un délai suffisant, le ministre renvoie l'affaire au gouverneur en conseil.

Étapes de la consultation

(2) Avant de renvoyer une affaire au gouverneur en conseil conformément au paragraphe (1) relativement à une province, le ministre :

(*a*) send by registered mail to the minister responsible for health care in the province a notice of concern with respect to any problem foreseen;

(*b*) seek any additional information available from the province with respect to the problem through bilateral discussions, and make a report to the province within ninety days after sending the notice of concern; and

(*c*) if requested by the province, meet within a reasonable period of time to discuss the report.

a) envoie par courrier recommandé à son homologue chargé de la santé dans la province un avis sur tout problème éventuel;

b) tente d'obtenir de la province, par discussions bilatérales, tout renseignement additionnel disponible sur le problème et fait rapport à la province dans les quatre-vingt-dix jours suivant l'envoi de l'avis;

c) si la province le lui demande, tient une réunion dans un délai acceptable afin de discuter du rapport.

Where no consultation can be achieved

(3) The Minister may act without consultation under subsection (1) if the Minister is of the opinion that a sufficient time has expired after reasonable efforts to achieve consultation and that consultation will not be achieved.

1984, c. 6, s. 14.

Impossibilité de consultation

(3) Le ministre peut procéder au renvoi prévu au paragraphe (1) sans consultation préalable s'il conclut à l'impossibilité d'obtenir cette consultation malgré des efforts sérieux déployés à cette fin au cours d'un délai convenable.

1984, ch. 6, art. 14.

Order reducing or withholding contribution

15. (1) Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan of a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 or that a province has failed to comply with any condition set out in section 13, the Governor in Council may, by order,

(*a*) direct that any cash contribution to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or

(*b*) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution to that province for a fiscal year be withheld.

Décret de réduction ou de retenue

15. (1) Si l'affaire lui est renvoyée en vertu de l'article 14 et qu'il estime que le régime d'assurance-santé de la province ne satisfait pas ou plus aux conditions visées aux articles 8 à 12 ou que la province ne s'est pas conformée aux conditions visées à l'article 13, le gouverneur en conseil peut, par décret :

a) soit ordonner, pour chaque manquement, que la contribution pécuniaire d'un exercice à la province soit réduite du montant qu'il estime indiqué, compte tenu de la gravité du manquement;

b) soit, s'il l'estime indiqué, ordonner la retenue de la totalité de la contribution pécuniaire d'un exercice à la province.

Amending orders

(2) The Governor in Council may, by order, repeal or amend any order made under subsection (1) where the Governor in Council is of the opinion that the repeal or amendment is warranted in the circumstances.

Modification des décrets

(2) Le gouverneur en conseil peut, par décret, annuler ou modifier un décret pris en vertu du paragraphe (1) s'il l'estime justifié dans les circonstances.

Notice of order

(3) A copy of each order made under this section together with a statement of any findings on which the order was based shall be sent forthwith by registered mail to the government of the province concerned and the Minister shall cause the order and statement to be laid before each House of Parliament on any of the

Avis

(3) Le texte de chaque décret pris en vertu du présent article de même qu'un exposé des motifs sur lesquels il est fondé sont envoyés sans délai par courrier recommandé au gouvernement de la province concernée; le ministre fait déposer le texte du décret et celui de l'exposé devant chaque chambre du Parlement dans

first fifteen days on which that House is sitting after the order is made.

les quinze premiers jours de séance de celle-ci suivant la prise du décret.

Commencement of order

(4) An order made under subsection (1) shall not come into force earlier than thirty days after a copy of the order has been sent to the government of the province concerned under subsection (3).

(4) Un décret pris en vertu du paragraphe (1) ne peut entrer en vigueur que trente jours après l'envoi au gouvernement de la province concernée du texte du décret aux termes du paragraphe (3).

Entrée en vigueur du décret

R.S., 1985, c. C-6, s. 15; 1995, c. 17, s. 38.

L.R. (1985), ch. C-6, art. 15; 1995, ch. 17, art. 38.

Reimposition of reductions or withholdings

16. In the case of a continuing failure to satisfy any of the criteria described in sections 8 to 12 or to comply with any condition set out in section 13, any reduction or withholding under section 15 of a cash contribution to a province for a fiscal year shall be reimposed for each succeeding fiscal year as long as the Minister is satisfied, after consultation with the minister responsible for health care in the province, that the default is continuing.

16. En cas de manquement continu aux conditions visées aux articles 8 à 12 ou à l'article 13, les réductions ou retenues de la contribution pécuniaire à une province déjà appliquées pour un exercice en vertu de l'article 15 lui sont appliquées de nouveau pour chaque exercice ultérieur où le ministre estime, après consultation de son homologue chargé de la santé dans la province, que le manquement se continue.

Nouvelle application des réductions ou retenues

R.S., 1985, c. C-6, s. 16; 1995, c. 17, s. 39.

L.R. (1985), ch. C-6, art. 16; 1995, ch. 17, art. 39.

When reduction or withholding imposed

17. Any reduction or withholding under section 15 or 16 of a cash contribution may be imposed in the fiscal year in which the default that gave rise to the reduction or withholding occurred or in the following fiscal year.

17. Toute réduction ou retenue d'une contribution pécuniaire visée aux articles 15 ou 16 peut être appliquée pour l'exercice où le manquement à son origine a eu lieu ou pour l'exercice suivant.

Application aux exercices ultérieurs

R.S., 1985, c. C-6, s. 17; 1995, c. 17, s. 39.

L.R. (1985), ch. C-6, art. 17; 1995, ch. 17, art. 39.

EXTRA-BILLING AND USER CHARGES

SURFACTURATION ET FRAIS MODÉRATEURS

Extra-billing

18. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists.

18. Une province n'a droit, pour un exercice, à la pleine contribution pécuniaire visée à l'article 5 que si, aux termes de son régime d'assurance-santé, elle ne permet pas pour cet exercice le versement de montants à l'égard des services de santé assurés qui ont fait l'objet de surfacturation par les médecins ou les dentistes.

Surfacturation

1984, c. 6, s. 18.

1984, ch. 6, art. 18.

User charges

19. (1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province.

19. (1) Une province n'a droit, pour un exercice, à la pleine contribution pécuniaire visée à l'article 5 que si, aux termes de son régime d'assurance-santé, elle ne permet pour cet exercice l'imposition d'aucuns frais modérateurs.

Frais modérateurs

Limitation

(2) Subsection (1) does not apply in respect of user charges for accommodation or meals provided to an in-patient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution.

(2) Le paragraphe (1) ne s'applique pas aux frais modérateurs imposés pour l'hébergement ou les repas fournis à une personne hospitalisée qui, de l'avis du médecin traitant, souffre d'une maladie chronique et séjourne de façon plus ou

Réserve

1984, c. 6, s. 19.

moins permanente à l'hôpital ou dans une autre institution.

1984, ch. 6, art. 19.

Deduction for extra-billing

20. (1) Where a province fails to comply with the condition set out in section 18, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged through extra-billing by medical practitioners or dentists in the province in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Déduction en cas de surfacturation

20. (1) Dans le cas où une province ne se conforme pas à la condition visée à l'article 18, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d'après les renseignements fournis conformément aux règlements, égal au total de la surfacturation effectuée par les médecins ou les dentistes dans la province pendant l'exercice ou, si les renseignements n'ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Deduction for user charges

(2) Where a province fails to comply with the condition set out in section 19, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged in the province in respect of user charges to which section 19 applies in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Déduction en cas de frais modérateurs

(2) Dans le cas où une province ne se conforme pas à la condition visée à l'article 19, il est déduit de la contribution pécuniaire à cette dernière pour un exercice un montant, déterminé par le ministre d'après les renseignements fournis conformément aux règlements, égal au total des frais modérateurs assujettis à l'article 19 imposés dans la province pendant l'exercice ou, si les renseignements n'ont pas été fournis conformément aux règlements, un montant estimé par le ministre égal à ce total.

Consultation with province

(3) The Minister shall not estimate an amount under subsection (1) or (2) without first undertaking to consult the minister responsible for health care in the province concerned.

Consultation de la province

(3) Avant d'estimer un montant visé au paragraphe (1) ou (2), le ministre se charge de consulter son homologue responsable de la santé dans la province concernée.

Separate accounting in Public Accounts

(4) Any amount deducted under subsection (1) or (2) from a cash contribution in any of the three consecutive fiscal years the first of which commences on April 1, 1984 shall be accounted for separately in respect of each province in the Public Accounts for each of those fiscal years in and after which the amount is deducted.

Comptabilisation

(4) Les montants déduits d'une contribution pécuniaire en vertu des paragraphes (1) ou (2) pendant les trois exercices consécutifs dont le premier commence le 1er avril 1984 sont comptabilisés séparément pour chaque province dans les comptes publics pour chacun de ces exercices pendant et après lequel le montant a été déduit.

Refund to province

(5) Where, in any of the three fiscal years referred to in subsection (4), extra-billing or user charges have, in the opinion of the Minister, been eliminated in a province, the total amount deducted in respect of extra-billing or user charges, as the case may be, shall be paid to the province.

Remboursement à la province

(5) Si, de l'avis du ministre, la surfacturation ou les frais modérateurs ont été supprimés dans une province pendant l'un des trois exercices visés au paragraphe (4), il est versé à cette dernière le montant total déduit à l'égard de la surfacturation ou des frais modérateurs, selon le cas.

Saving

(6) Nothing in this section restricts the power of the Governor in Council to make any order under section 15.

1984, c. 6, s. 20.

Réserve

(6) Le présent article n'a pas pour effet de limiter le pouvoir du gouverneur en conseil de prendre le décret prévu à l'article 15.

1984, ch. 6, art. 20.

When deduction made

21. Any deduction from a cash contribution under section 20 may be made in the fiscal year in which the matter that gave rise to the deduction occurred or in the following two fiscal years.

1984, c. 6, s. 21.

Application aux exercices ultérieurs

21. Toute déduction d'une contribution pécuniaire visée à l'article 20 peut être appliquée pour l'exercice où le fait à son origine a eu lieu ou pour les deux exercices suivants.

1984, ch. 6, art. 21.

REGULATIONS

RÈGLEMENTS

Regulations

22. (1) Subject to this section, the Governor in Council may make regulations for the administration of this Act and for carrying its purposes and provisions into effect, including, without restricting the generality of the foregoing, regulations

(*a*) defining the services referred to in paragraphs (*a*) to (*d*) of the definition "extended health care services" in section 2;

(*b*) prescribing the services excluded from hospital services;

(*c*) prescribing the types of information that the Minister may require under paragraph 13(*a*) and the times at which and the manner in which that information shall be provided; and

(*d*) prescribing the manner in which recognition to the Canada Health Transfer is required to be given under paragraph 13(*b*).

Règlements

22. (1) Sous réserve des autres dispositions du présent article, le gouverneur en conseil peut, par règlement, prendre toute mesure d'application de la présente loi et, notamment :

a) définir les services visés aux alinéas *a*) à *d*) de la définition de « services complémentaires de santé » à l'article 2;

b) déterminer les services exclus des services hospitaliers;

c) déterminer les genres de renseignements dont peut avoir besoin le ministre en vertu de l'alinéa 13*a*) et fixer les modalités de temps et autres de leur communication;

d) prévoir la façon dont il doit être fait état du Transfert en vertu de l'alinéa 13*b*).

Agreement of provinces

(2) Subject to subsection (3), no regulation may be made under paragraph (1)(*a*) or (*b*) except with the agreement of each of the provinces.

Consentement des provinces

(2) Sous réserve du paragraphe (3), il ne peut être pris de règlements en vertu des alinéas (1)*a*) ou *b*) qu'avec l'accord de chaque province.

Exception

(3) Subsection (2) does not apply in respect of regulations made under paragraph (1)(*a*) if they are substantially the same as regulations made under the *Federal-Provincial Fiscal Arrangements Act*, as it read immediately before April 1, 1984.

Exception

(3) Le paragraphe (2) ne s'applique pas aux règlements pris en vertu de l'alinéa (1)*a*) s'ils sont sensiblement comparables aux règlements pris en vertu de la *Loi sur les arrangements fiscaux entre le gouvernement fédéral et les provinces*, dans sa version précédant immédiatement le 1er avril 1984.

Consultation with provinces

(4) No regulation may be made under paragraph (1)(*c*) or (*d*) unless the Minister has first consulted with the ministers responsible for health care in the provinces.

R.S., 1985, c. C-6, s. 22; 1995, c. 17, s. 40; 2012, c. 19, s. 410(E).

Consultation des provinces

(4) Il ne peut être pris de règlements en vertu des alinéas (1)*c*) ou *d*) que si le ministre a au préalable consulté ses homologues chargés de la santé dans les provinces.

L.R. (1985), ch. C-6, art. 22; 1995, ch. 17, art. 40; 2012, ch. 19, art. 410(A).

REPORT TO PARLIAMENT

RAPPORT AU PARLEMENT

Annual report by Minister

23. The Minister shall, as soon as possible after the termination of each fiscal year and in any event not later than December 31 of the

Rapport annuel du ministre

23. Au plus tard pour le 31 décembre de chaque année, le ministre établit dans les meilleurs délais un rapport sur l'application de

next fiscal year, make a report respecting the administration and operation of this Act for that fiscal year, including all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed.

1984, c. 6, s. 23.

la présente loi au cours du précédent exercice, en y incluant notamment tous les renseignements pertinents sur la mesure dans laquelle les régimes provinciaux d'assurance-santé et les provinces ont satisfait aux conditions d'octroi et de versement prévues à la présente loi; le ministre fait déposer le rapport devant chaque chambre du Parlement dans les quinze premiers jours de séance de celle-ci suivant son achèvement.

1984, ch. 6, art. 23.

CANADA

CONSOLIDATION

CODIFICATION

Extra-billing and User Charges Information Regulations

Règlement concernant les renseignements sur la surfacturation et les frais modérateurs

SOR/86-259

DORS/86-259

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OFFICIAL STATUS OF CONSOLIDATIONS

Subsections 31(1) and (3) of the *Legislation Revision and Consolidation Act*, in force on June 1, 2009, provide as follows:

Published consolidation is evidence

31. (1) Every copy of a consolidated statute or consolidated regulation published by the Minister under this Act in either print or electronic form is evidence of that statute or regulation and of its contents and every copy purporting to be published by the Minister is deemed to be so published, unless the contrary is shown.

...

Inconsistencies in regulations

(3) In the event of an inconsistency between a consolidated regulation published by the Minister under this Act and the original regulation or a subsequent amendment as registered by the Clerk of the Privy Council under the *Statutory Instruments Act*, the original regulation or amendment prevails to the extent of the inconsistency.

CARACTÈRE OFFICIEL DES CODIFICATIONS

Les paragraphes 31(1) et (3) de la *Loi sur la révision et la codification des textes législatifs*, en vigueur le 1er juin 2009, prévoient ce qui suit :

Codifications comme élément de preuve

31. (1) Tout exemplaire d'une loi codifiée ou d'un règlement codifié, publié par le ministre en vertu de la présente loi sur support papier ou sur support électronique, fait foi de cette loi ou de ce règlement et de son contenu. Tout exemplaire donné comme publié par le ministre est réputé avoir été ainsi publié, sauf preuve contraire.

[...]

Incompatibilité — règlements

(3) Les dispositions du règlement d'origine avec ses modifications subséquentes enregistrées par le greffier du Conseil privé en vertu de la *Loi sur les textes réglementaires* l'emportent sur les dispositions incompatibles du règlement codifié publié par le ministre en vertu de la présente loi.

REGULATIONS PRESCRIBING THE TYPES OF INFORMATION THAT THE MINISTER OF NATIONAL HEALTH AND WELFARE MAY REQUIRE UNDER PARAGRAPH 13(A) OF THE CANADA HEALTH ACT IN RESPECT OF EXTRA-BILLING AND USER CHARGES AND THE TIMES AT WHICH AND THE MANNER IN WHICH SUCH INFORMATION SHALL BE PROVIDED BY THE GOVERNMENT OF EACH PROVINCE

SHORT TITLE

1. These Regulations may be cited as the *Extra-billing and User Charges Information Regulations*.

INTERPRETATION

2. In these Regulations,

"Act" means the *Canada Health Act*; (*Loi*)

"Minister" means the Minister of National Health and Welfare; (*ministre*)

"fiscal year" means the period beginning on April 1 in one year and ending on March 31 in the following year. (*exercice*)

TYPES OF INFORMATION

3. For the purposes of paragraph 13(*a*) of the Act, the Minister may require the government of a province to provide the Minister with information of the following types with respect to extra-billing in the province in a fiscal year:

(*a*) an estimate of the aggregate amount that, at the time the estimate is made, is expected to be charged through extra-billing, including an explanation regarding the method of determination of the estimate; and

(*b*) a financial statement showing the aggregate amount actually charged through extra-billing, including an explanation regarding the method of determination of the aggregate amount.

RÈGLEMENT DÉTERMINANT LES GENRES DE RENSEIGNEMENTS DONT PEUT AVOIR BESOIN LE MINISTRE DE LA SANTÉ NATIONALE ET DU BIEN-ÊTRE SOCIAL EN VERTU DE L'ALINÉA 13*A*) DE LA LOI CANADIENNE SUR LA SANTÉ QUANT À LA SURFACTURATION ET AUX FRAIS MODÉRATEURS ET FIXANT LES MODALITÉS DE TEMPS ET LES AUTRES MODALITÉS DE LEUR COMMUNICATION PAR LE GOUVERNEMENT DE CHAQUE PROVINCE

TITRE ABRÉGÉ

1. *Règlement concernant les renseignements sur la surfacturation et les frais modérateurs*.

DÉFINITIONS

2. Les définitions qui suivent s'appliquent au présent règlement.

« exercice » La période commençant le 1er avril d'une année et se terminant le 31 mars de l'année suivante. (*fiscal year*)

« Loi » La *Loi canadienne sur la santé*. (*Act*)

« ministre » Le ministre de la Santé nationale et du Bien-être social. (*Minister*)

GENRE DE RENSEIGNEMENTS

3. Pour l'application de l'alinéa 13*a*) de la Loi, le ministre peut exiger que le gouvernement d'une province lui fournisse les renseignements suivants sur les montants de la surfacturation pratiquée dans la province au cours d'un exercice :

a) une estimation du montant total de la surfacturation, à la date de l'estimation, accompagnée d'une explication de la façon dont cette estimation a été obtenue;

b) un état financier indiquant le montant total de la surfacturation effectivement imposée, accompagné d'une explication de la façon dont cet état a été établi.

4. For the purposes of paragraph 13(*a*) of the Act, the Minister may require the government of a province to provide the Minister with information of the following types with respect to user charges in the province in a fiscal year:

(*a*) an estimate of the aggregate amount that, at the time the estimate is made, is expected to be charged in respect of user charges to which section 19 of the Act applies, including an explanation regarding the method of determination of the estimate; and

(*b*) a financial statement showing the aggregate amount actually charged in respect of user charges to which section 19 of the Act applies, including an explanation regarding the method of determination of the aggregate amount.

TIMES AND MANNER OF FILING INFORMATION

5. (1) The government of a province shall provide the Minister with such information, of the types prescribed by sections 3 and 4, as the Minister may reasonably require, at the following times:

(*a*) in respect of the estimates referred to in paragraphs 3(*a*) and 4(*a*), before April 1 of the fiscal year to which they relate; and

(*b*) in respect of the financial statements referred to in paragraphs 3(*b*) and 4(*b*), before the sixteenth day of the twenty-first month following the end of the fiscal year to which they relate.

(2) The government of a province may, at its discretion, provide the Minister with adjustments to the estimates referred to in paragraphs 3(*a*) and 4(*a*) before February 16 of the fiscal year to which they relate.

(3) The information referred to in subsections (1) and (2) shall be transmitted to the Minister by the most practical means of communication.

4. Pour l'application de l'alinéa 13*a*) de la Loi, le ministre peut exiger que le gouvernement d'une province lui fournisse les renseignements suivants sur les montants des frais modérateurs imposés dans la province au cours d'un exercice :

a) une estimation du montant total, à la date de l'estimation, des frais modérateurs visés à l'article 19 de la Loi, accompagnée d'une explication de la façon dont cette estimation a été obtenue;

b) un état financier indiquant le montant total des frais modérateurs visés à l'article 19 de la Loi effectivement imposés dans la province, accompagné d'une explication de la façon dont le bilan a été établi.

COMMUNICATION DE RENSEIGNEMENTS

5. (1) Le gouvernement d'une province doit communiquer au ministre les renseignements visés aux articles 3 et 4, dont le ministre peut normalement avoir besoin, selon l'échéancier suivant :

a) pour les estimations visées aux alinéas 3*a*) et 4*a*), avant le 1er avril de l'exercice visé par ces estimations;

b) pour les états financiers visés aux alinéas 3*b*) et 4*b*), avant le seizième jour du vingt et unième mois qui suit la fin de l'exercice visé par ces états.

(2) Le gouvernement d'une province peut, à sa discrétion, fournir au ministre des ajustements aux estimations prévues aux alinéas 3*a*) et 4*a*), avant le 16 février de l'année financière visée par ces estimations.

(3) Les renseignements visés aux paragraphes (1) et (2) doivent être expédiés au ministre par le moyen de communication le plus pratique.

ANNEX B

POLICY INTERPRETATION LETTERS

There are two key policy statements that clarify the federal position on the *Canada Health Act*. These statements have been made in the form of ministerial letters from former Federal Health Ministers to their provincial and territorial counterparts.

EPP LETTER

In June 1985, approximately one year following the passage of the *Canada Health Act* in Parliament, then-federal Health Minister Jake Epp wrote to his provincial and territorial counterparts to set out and confirm the federal position on the interpretation and implementation of the *Canada Health Act*.

Minister Epp's letter followed several months of consultation with his provincial and territorial counterparts. The letter sets forth statements of federal policy intent which clarify the criteria, conditions and regulatory provisions of the *Canada Health Act*. These clarifications have been used by the federal government in the assessment and interpretation of compliance with the Act. The Epp letter remains an important reference for interpretation of the Act.

FEDERAL POLICY ON PRIVATE CLINICS

Between February 1994 and December 1994, a series of seven federal/provincial/territorial meetings dealing wholly or in part with private clinics took place. At issue was the growth of private clinics providing medically necessary services funded partially by the public system and partially by patients and its impact on Canada's universal, publicly funded health care system.

At the Federal/Provincial/Territorial Health Ministers Meeting of September 1994 in Halifax all Ministers of Health present, with the exception of Alberta's Health Minister, agreed to "take whatever steps are required to regulate the development of private clinics in Canada."

Diane Marleau, the federal Minister of Health at the time, wrote to all provincial and territorial Ministers of Health on January 6, 1995 to announce the new Federal Policy on Private Clinics. The Minister's letter provided the federal interpretation of the *Canada Health Act* as it relates to the issue of facility fees charged directly to patients receiving medically necessary services at private clinics. The letter stated that the definition of "hospital" contained in the *Canada Health Act*, includes any facility that provides acute, rehabilitative or chronic care. Thus, when a provincial/territorial health insurance plan pays the physician fee for a medically necessary service delivered at a private clinic, it must also pay the facility fee or face a deduction from federal transfer payments.

[Following is the text of the letter sent on June 18, 1985 to all provincial and territorial Ministers of Health by the Honourable Jake Epp, Federal Minister of Health and Welfare. (Note: Minister Epp sent the French equivalent of this letter to Quebec on July 15, 1985.)]

June 18, 1985
OTTAWA, K1A 0K9

Dear Minister:

Having consulted with all provincial and territorial Ministers of Health over the past several months, both individually and at the meeting in Winnipeg on May 16 and 17, I would like to confirm for you my intentions regarding the interpretation and implementation of the *Canada Health Act*. I would particularly appreciate if you could provide me with a written indication of your views on the attached proposals for regulations in order that I may act to have these officially put in place as soon as conveniently possible. Also, I will write to you further with regard to the material I will need to prepare the required annual report to Parliament.

As indicated at our meeting in Winnipeg, I intend to honour and respect provincial jurisdiction and authority in matters pertaining to health and the provision of health care services. I am persuaded, by conviction and experience, that more can be achieved through harmony and collaboration than through discord and confrontation.

With regard to the *Canada Health Act*, I can only conclude from our discussions that we together share a public trust and are mutually and equally committed to the maintenance and improvement of a universal, comprehensive, accessible and portable health insurance system, operated under public auspices for the benefit of all residents of Canada.

Our discussions have reinforced my belief that you require sufficient flexibility and administrative versatility to operate and administer your health care insurance plans. You know far better than I ever can, the needs and priorities of your residents, in light of geographic and economic considerations. Moreover, it is essential that provinces have the freedom to exercise their primary responsibility for the provision of personal health care services.

At the same time, I have come away from our discussions sensing a desire to sustain a positive federal involvement and role—both financial and otherwise—to support and assist provinces in their efforts dedicated to the fundamental objectives of the health care system: protecting, promoting and restoring the physicaland mental well-being of Canadians. As a group, provincial/territorial Health Ministers accept a co-operative partnership with the federal government based primarily on the contributions it authorizes for purposes of providing insured and extended health care services.

I might also say that the *Canada Health Act* does not respond to challenges facing the health care system. I look forward to working collaboratively with you as we address challenges such as rapidly advancing medical technology and an aging population and strive to develop health promotion strategies and health care delivery alternatives.

Returning to the immediate challenge of implementing the *Canada Health Act*, I want to set forth some reasonably comprehensive statements of federal policy intent, beginning with each of the criteria contained in the Act.

Public Administration

This criterion is generally accepted. The intent is that the provincial health care insurance plans be administered by a public authority, accountable to the provincial government for decision-making on benefit levels and services, and whose records and accounts are publicly audited.

Comprehensiveness

The intent of the *Canada Health Act* is neither to expand nor contract the range of insured services covered under previous federal legislation. The range of insured services encompasses medically necessary hospital care, physician services and surgical-dental services which require a hospital for their proper performance. Hospital plans are expected to cover in-patient and out-patient hospital services associated with the provision of acute, rehabilitative and chronic care. As regards physician services, the range of

insured services generally encompasses medically required services rendered by licensed medical practitioners as well as surgical-dental procedures that require a hospital for proper performance. Services rendered by other health care practitioners, except those required to provide necessary hospital services, are not subject to the Act's criteria.

Within these broad parameters, provinces, along with medical professionals, have the prerogative and responsibility for interpreting what physician services are medically necessary. As well, provinces determine which hospitals and hospital services are required to provide acute, rehabilitative or chronic care.

Universality

The intent of the *Canada Health Act* is to ensure that all bonafide residents of all provinces be entitled to coverage and to the benefits under one of the twelve provincial/territorial health care insurance plans. However, eligible residents do have the option not to participate under a provincial plan should they elect to do so.

The Agreement on Eligibility and Portability provides some helpful guidelines with respect to the determination of residency status and arrangements for obtaining and maintaining coverage. Its provisions are compatible with the *Canada Health Act*.

I want to say a few words about premiums. Unquestionably, provinces have the right to levy taxes and the *Canada Health Act* does not infringe upon that right. A premium scheme per se is not precluded by the Act, provided that the provincial health care insurance plan is operated and administered in a manner that does not deny coverage or preclude access to necessary hospital and physician services to bonafide residents of a province. Administrative arrangements should be such that residents are not precluded from or do not forego coverage by reason of an inability to pay premiums.

I am acutely aware of problems faced by some provinces in regard to tourists and visitors who may require health services while travelling in Canada. I will be undertaking a review of the current practices and procedures with my Cabinet colleagues, the Minister of External Affairs, and the Minister of Employment and Immigration, to ensure all reasonable means are taken to inform prospective visitors to Canada of the need to protect themselves with adequate health insurance coverage before entering the country.

In summary, I believe all of us as Ministers of Health are committed to the objective of ensuring that all duly qualified residents of a province obtain and retain entitlement to insured health services on uniform terms and conditions.

Portability

The intent of the portability provisions of the *Canada Health Act* is to provide insured persons continuing protection under their provincial health care insurance plan when they are temporarily absent from their province of residence or when moving from province to province. While temporarily in another province of Canada, bonafide residents should not be subject to out-of-pocket costs or charges for necessary hospital and physician services. Providers should be assured of reasonable levels of payment in respect of the cost of those services.

Insofar as insured services received while outside of Canada are concerned, the intent is to assure reasonable indemnification in respect of the cost of necessary emergency hospital or physician services or for referred services not available in a province or in neighbouring provinces. Generally speaking, payment formulae tied to what would have been paid for similar services in a province would be acceptable for purposes of the *Canada Health Act*.

In my discussions with provincial/territorial Ministers, I detected a desire to achieve these portability objectives and to minimize the difficulties that Canadians may encounter when moving or travelling about in Canada. In order that Canadians may maintain their health insurance coverage and obtain benefits or services without undue impediment, I believe that all provincial/territorial Health Ministers are interested in seeing these services provided more efficiently and economically.

Significant progress has been made over the past few years by way of reciprocal arrangements which contribute to the achievement of the in-Canada portability objectives of the *Canada Health Act*. These arrangements do not interfere with the rights and prerogatives of provinces to determine and provide the coverage for services rendered in another province. Likewise, they do not deter provinces from exercising reasonable controls through prior approval mechanisms for elective procedures. I recognize that work remains to be done respecting interprovincial payment arrangements to achieve this objective, especially as it pertains to physician services.

I appreciate that all difficulties cannot be resolved overnight and that provincial plans will require sufficient time to meet the objective of ensuring no direct charges to patients for necessary hospital and physician services provided in other provinces.

For necessary services provided out-of-Canada, I am confident that we can establish acceptable standards of indemnification for essential physician and hospital services. The legislation does not define a particular formula and I would be pleased to have your views.

In order that our efforts can progress in a coordinated manner, I would propose that the Federal-Provincial Advisory Committee on Institutional and Medical Services be charged with examining various options and recommending arrangements to achieve the objectives within one year.

Reasonable Accessibility

The Act is fairly clear with respect to certain aspects of accessibility. The Act seeks to discourage all point-of-service charges for insured services provided to insured persons and to prevent adverse discrimination against any population group with respect to charges for, or necessary use of, insured services. At the same time, the Act accents a partnership between the providers of insured services and provincial plans, requiring that provincial plans have in place reasonable systems of payment or compensation for their medical practitioners in order to ensure reasonable access to users. I want to emphasize my intention to respect provincial prerogatives regarding the organization, licensing, supply, distribution of health manpower, as well as the resource allocation and priorities for health services. I want to assure you that the reasonable access provision will not be used to intervene or interfere directly in matters such as the physical and geographic availability of services or provincial governance of the institutions and professions that provide insured services. Inevitably, major issues or concerns regarding access to health care services will come to my attention. I want to assure you that my Ministry will work through and with provincial/territorial Ministers in addressing such matters.

My aim in communicating my intentions with respect to the criteria in the *Canada Health Act* is to allow us to work together in developing our national health insurance scheme. Through continuing dialogue, open and willing exchange of information and mutually understood rules of the road, I believe that we can implement the *Canada Health Act* without acrimony and conflict. It is my preference that provincial/territorial Ministers themselves be given an opportunity to interpret and apply the criteria of the *Canada Health Act* to their respective health care insurance plans. At the same time, I believe that all provincial/territorial Health Ministers understand and respect my accountability to the Parliament of Canada, including an annual report on the operation of provincial health care insurance plans with regard to these fundamental criteria.

Conditions

This leads me to the conditions related to the recognition of federal contributions and to the provision of information, both of which may be specified in regulations. In these matters, I will be guided by the following principles:

1. to make as few regulations as possible and only if absolutely necessary;
2. to rely on the goodwill of Ministers to afford appropriate recognition of Canada's role and contribution and to provide necessary information voluntarily for purposes of administering the Act and reporting to Parliament;
3. to employ consultation processes and mutually beneficial information exchanges as the preferred ways and means of implementing and administering the *Canada Health Act*;
4. to use existing means of exchanging information of mutual benefit to all our governments.

Regarding recognition by provincial/territorial governments of federal health contributions, I am satisfied that we can easily agree on appropriate recognition, in the normal course of events. The best form of recognition in my view is the demonstration to the public that as Ministers of Health we are working together in the interests of the taxpayer and patient.

In regard to information, I remain committed to maintaining and improving national data systems on a collaborative and co-operative basis. These systems serve many purposes and provide governments, as well as other agencies, organizations, and the general public, with essential data about our health care system and the health status of our population. I foresee a continuing, co-operative partnership committed to maintaining and improving health information systems in such areas as morbidity, mortality, health status, health services operations, utilization, health care costs and financing.

I firmly believe that the federal government need not regulate these matters. Accordingly, I do not intend to use the regulatory authority respecting information requirements under the *Canada Health Act* to expand, modify or change these broad-based data systems and exchanges. In order to keep information flows related to the *Canada Health Act* to an economical minimum, I see only two specific and essential information transfer mechanisms:

1. estimates and statements on extra-billing and user charges;
2. an annual provincial statement (perhaps in the form of a letter to me) to be submitted approximately six months after the completion of each fiscal year, describing the respective provincial health care insurance plan's operations as they relate to the criteria and conditions of the *Canada Health Act*.

Concerning Item 1 above, I propose to put in place on-going regulations that are identical in content to those that have been accepted for 1985–86. Draft regulations are attached as Annex I. To assist with the preparation of the "annual provincial statement" referred to in Item 2 above, I have developed the general guidelines attached as Annex II. Beyond these specific exchanges, I am confident that voluntary, mutually beneficial exchange of such subjects as Acts, regulations and program descriptions will continue.

One matter brought up in the course of our earlier meetings, is the question of whether estimates or deductions of user charges and extra-billing should be based on "amounts charged" or "amounts collected". The Act clearly states that deductions are to be based on amounts charged. However, with respect to user fees, certain provincial plans appear to pay these charges indirectly on behalf of certain individuals. Where a provincial plan demonstrates that it reimburses providers for amounts charged but not collected, say in respect of social assistance recipients or unpaid accounts, consideration will be given to adjusting estimates/deductions accordingly.

I want to emphasize that where a provincial plan does authorize user charges, the entire scheme must be consistent with the intent of the reasonable accessibility criterion as set forth [in this letter].

Regulations

Aside from the recognition and information regulations referred to above, the Act provides for regulations concerning hospital services exclusions and regulations defining extended health care services.

As you know, the Act provides that there must be consultation and agreement of each and every province with respect to such regulations. My consultations with you have brought to light few concerns with the attached draft set of Exclusions from Hospital Services Regulations.

Likewise, I did not sense concerns with proposals for regulations defining Extended Health Care Services. These help provide greater clarity for provinces to interpret and administer current plans and programs. They do not alter significantly or substantially those that have been in force for eight years under Part VI of the *Federal Post-Secondary Education and Health Contributions Act* (1977). It may well be, however, as we begin to examine the future challenges to health care that we should re-examine these definitions.

This letter strives to set out flexible, reasonable and clear ground rules to facilitate provincial, as much as federal, administration of the *Canada Health Act*. It encompasses many complex matters including criteria interpretations, federal policy concerning conditions and proposed regulations. I realize, of course, that a letter of this sort cannot cover every single matter of concern to every provincial Minister of Health. Continuing dialogue and communi-cation are essential.

In conclusion, may I express my appreciation for your assistance in bringing about what I believe is a generally accepted concurrence of views in respect of interpretation and implementation. As I mentioned at the outset of this letter, I would appreciate an early written indication of your views on the proposals for regulations appended to this letter. It is my intention to write to you in the near future with regard to the voluntary information exchanges which we have discussed in relation to administering the Act and reporting to Parliament.

Yours truly,

Jake Epp
Attachments

[Following is the text of the letter sent on January 6, 1995 to all provincial and territorial Ministers of Health by the Federal Minister of Health, the Honourable Diane Marleau.]

January 6, 1995

Dear Minister:

RE: *Canada Health Act*

The *Canada Health Act* has been in force now for just over a decade. The principles set out in the Act (public administration, comprehensiveness, universality, portability and accessibility) continue to enjoy the support of all provincial and territorial governments. This support is shared by the vast majority of Canadians. At a time when there is concern about the potential erosion of the publicly funded and publicly administered health care system, it is vital to safeguard these principles.

As was evident and a concern to many of us at the recent Halifax meeting, a trend toward divergent interpretations of the Act is developing. While I will deal with other issues at the end of this letter, my primary concern is with private clinics and facility fees. The issue of private clinics is not new to us as Ministers of Health; it formed an important part of our discussions in Halifax last year. For reasons I will set out below, I am convinced that the growth of a second tier of health care facilities providing medically necessary services that operate, totally or in large part, outside the publicly funded and publicly administered system, presents a serious threat to Canada's health care system.

Specifically, and most immediately, I believe the facility fees charged by private clinics for medically necessary services are a major problem which must be dealt with firmly. It is my position that such fees constitute user charges and, as such, contravene the principle of accessibility set out in the *Canada Health Act*.

While there is no definition of facility fees in federal or most provincial legislation, the term, generally speaking, refers to amounts charged for non-physician (or "hospital") services provided at clinics and not reimbursed by the province. Where these fees are charged for medically necessary services in clinics which receive funding for these services under a provincial health insurance plan, they constitute a financial barrier to access. As a result, they violate the user charge provision of the Act (section 19).

Facility fees are objectionable because they impede access to medically necessary services. Moreover, when clinics which receive public funds for medically necessary services also charge facility fees, people who can afford the fees are being directly subsidized by all other Canadians. This subsidization of two-tier health care is unacceptable.

The formal basis for my position on facility fees is twofold. The first is a matter of policy. In the context of contemporary health care delivery, an interpretation which permits facility fees for medically necessary services so long as the provincial health insurance plan covers physician fees runs counter to the spirit and intent of the Act. While the appropriate provision of many physician services at one time required an overnight stay in a hospital, advances in medical technology and the trend toward providing medical services in more accessible settings has made it possible to offer a wide range of medical procedures on an outpatient basis or outside of full-service hospitals. The accessibility criterion in the Act, of which the user charge provision is just a specific example, was clearly intended to ensure that Canadian residents receive all medically necessary care without financial or other barriers and regardless of venue. It must continue to mean that as the nature of medical practice evolves.

Second, as a matter of legal interpretation, the definition of "hospital" set out in the Act includes any facility which provides acute, rehabilitative or chronic care. This definition covers those health care facilities known as "clinics". As a matter of both policy and legal interpretation, therefore, where a provincial plan pays the physician fee for a medically necessary service delivered at a clinic, it must also pay for the related hospital services provided or face deductions for user charges.

I recognize that this interpretation will necessitate some changes in provinces where clinics currently charge facility fees for medically necessary services. As I do not wish to cause undue hardship to those provinces, I will commence enforcement of this interpretation as of October 15, 1995. This will allow the provinces the time to put into place the necessary legislative or regulatory framework. As of October 15, 1995, I will proceed to deduct from transfer payments any amounts charged for facility fees in respect of medically necessary services, as mandated by section 20 of the *Canada Health Act*. I believe this provides a reasonable transition period, given that all provinces have been aware of my concerns with respect to private clinics for some time, and given the promising headway already made by the Federal/Provincial/Territorial Advisory Committee on Health Services, which has been working for some time now on the issue of private clinics.

I want to make it clear that my intent is not to preclude the use of clinics to provide medically necessary services. I realize that in many situations they are a cost-effective way to deliver services, often in a technologically advanced manner. However, it is my intention to ensure that medically necessary services are provided on uniform terms and conditions, wherever they are offered. The principles of the *Canada Health Act* are supple enough to accommodate the evolution of medical science and of health care delivery. This evolution must not lead, however, to a two-tier system of health care.

I indicated earlier in this letter that, while user charges for medically necessary services are my most immediate concern, I am also concerned about the more general issues raised by the proliferation of private clinics. In particular, I am concerned about their potential to restrict access by Canadian residents to medically necessary services by eroding our publicly funded system. These concerns were reflected in the policy statement which resulted from the Halifax meeting. Ministers of Health present, with the exception of the Alberta Minister, agreed to:

> take whatever steps are required to regulate the development of private clinics in Canada, and to maintain a high quality, publicly funded medicare system.

Private clinics raise several concerns for the federal government, concerns which provinces share. These relate to:

- weakened public support for the tax funded and publicly administered system;
- the diminished ability of governments to control costs once they have shifted from the public to the private sector;
- the possibility, supported by the experience of other jurisdictions, that private facilities will concentrate on easy procedures, leaving public facilities to handle more complicated, costly cases; and
- the ability of private facilities to offer financial incentives to health care providers that could draw them away from the public system—resources may also be devoted to features which attract consumers, without in any way contributing to the quality of care.

The only way to deal effectively with these concerns is to regulate the operation of private clinics.

I now call on Ministers in provinces which have not already done so to introduce regulatory frameworks to govern the operation of private clinics. I would emphasize that, while my immediate concern is the elimination of user charges, it is equally important that these regulatory frameworks be put in place to ensure reasonable access to medically necessary services and to support the viability of the publicly funded and administered system in the future. I do not feel the implementation of such frameworks should be long delayed.

I welcome any questions you may have with respect to my position on private clinics and facility fees. My officials are willing to meet with yours at any time to discuss these matters. I believe that our officials need to focus their attention, in the coming weeks, on the broader concerns about private clinics referred to above.

As I mentioned at the beginning of this letter, divergent interpretations of the *Canada Health Act* apply to a number of other practices. It is always my preference that matters of interpretation of the Act be resolved by finding a Federal/Provincial/Territorial consensus consistent with its fundamental principles. I have therefore encouraged F/P/T consultations in all cases where there are disagreements. In situations such as out-of-province or out-of-country coverage, I remain committed to following through on these consultative processes as long as they continue to promise a satisfactory conclusion in a reasonable time.

In closing, I would like to quote Mr. Justice Emmett M. Hall. In 1980, he reminded us:

> " we, as a society, are aware that the trauma of illness, the pain of surgery, the slow decline to death, are burdens enough for the human being to bear without the added burden of medical or hospital bills penalizing the patient at the moment of vulnerability."

I trust that, mindful of these words, we will continue to work together to ensure the survival, and renewal, of what is perhaps our finest social project.

As the issues addressed in this letter are of great concern to Canadians, I intend to make this letter publicly available once all provincial Health Ministers have received it.

Yours sincerely,

Diane Marleau
Minister of Health

ANNEX C

DISPUTE AVOIDANCE AND RESOLUTION PROCESS UNDER THE CANADA HEALTH ACT

In April 2002, the Honourable A. Anne McLellan outlined in a letter to her provincial and territorial counterparts a *Canada Health Act* Dispute Avoidance and Resolution process, which was agreed to by pro-vinces and territories, except Quebec. The process meets federal and provincial/territorial interests of avoiding disputes related to the interpretation of the principles of the *Canada Health Act*, and when this is not possible, resolving disputes in a fair, transparent and timely manner.

The process includes the dispute avoidance activities of government-to-government information exchange; discussions and clarification of issues, as they arise; active participation of governments in ad hoc federal/provincial/territorial committees on *Canada Health Act* issues; and *Canada Health Act* advance assessments, upon request.

Where dispute avoidance activities prove unsuccessful, dispute resolution activities may be initiated, beginning with government-to-government fact-finding and negotiations. If these are unsuccessful, either Minister of Health involved may refer the issues to a third party panel to undertake fact-finding and provide advice and recommendations.

The federal Minister of Health has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister will take the panel's report into consideration.

In September 2004, the agreement reached between the provinces and territories in 2002 was formalized by First Ministers, thereby reaffirming their commitment to use the *Canada Health Act* dispute avoidance and resolution process to deal with *Canada Health Act* interpretation issues.

On the following pages you will find the full text of Minister McLellan's letter to the Honourable Gary Mar, as well as a fact sheet on the *Canada Health Act* Dispute Avoidance and Resolution process.

Minister of Health Ministre de la Santé

Ottawa, Canada K1A 0K9

April 2, 2002

The Honourable Gary Mar, M.L.A.
Minister of Health and Wellness
Province of Alberta
Room 323, Legislature Building
Edmonton, Alberta
T5K 2B6

Dear Mr. Mar:

I am writing in fulfilment of my commitment to move forward on dispute avoidance and resolution as it applies to the interpretation of the principles of the *Canada Health Act*.

I understand the importance provincial and territorial governments attach to having a third party provide advice and recommendations when differences occur regarding the interpretation of the *Canada Health Act*. This feature has been incorporated in the approach to the *Canada Health Act* Dispute Avoidance and Resolution process set out below. I believe this approach will enable us to avoid and resolve issues related to the interpretation of the principles of the *Canada Health Act* in a fair, transparent and timely manner.

Dispute Avoidance

The best way to resolve a dispute is to prevent it from occurring in the first place. The federal government has rarely resorted to penalties and only when all other efforts to resolve the issue have proven unsuccessful. Dispute avoidance has worked for us in the past and it can serve our shared interests in the future. Therefore, it is important that governments continue to participate actively in ad hoc federal/provincial/territorial committees on *Canada Health Act* issues and undertake government-to-government information exchange, discussions and clarification on issues as they arise.

Moreover, Health Canada commits to provide advance assessments to any province or territory upon request.

Dispute Resolution

Where the dispute avoidance activities between the federal government and a provincial or territorial government prove unsuccessful, either Minister of Health involved may initiate dispute resolution by writing to his or her counterpart. Such a letter would describe the issue in dispute. If initiated, dispute resolution will precede any action taken under the non-compliance provisions of the Act.

As a first step, governments involved in the dispute will, within 60 days of the date of the letter initiating the process, jointly:

- collect and share all relevant facts;
- prepare a fact-finding report;
- negotiate to resolve the issue in dispute; and
- prepare a report on how the issue was resolved.

If, however, there is no agreement on the facts, or if negotiations fail to resolve the issue, any Minister of Health involved in the dispute may initiate the process to refer the issue to a third party panel by writing to his or her counterpart. Within 30 days of the date of that letter, a panel will be struck. The panel will be composed of one provincial/territorial appointee and one federal appointee who, together, will select a chairperson. The panel will assess the issue in dispute in accordance with the provisions of the *Canada Health Act*, will undertake fact-finding and provide advice and recommendations. It will then report to the governments involved on the issue within 60 days of appointment.

The Minister of Health for Canada has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister of Health for Canada will take the panel's report into consideration.

Public Reporting

Governments will report publicly on *Canada Health Act* dispute avoidance and resolution activities, including any panel report.

I believe that the Government of Canada has followed through on its September 2000 Health Agreement commitments by providing funding of $21.1 billion in the fiscal framework and by working collaboratively in other areas identified in the agreement. I expect that provincial and territorial premiers and Health Ministers will honour their commitment to the health system accountability framework agreed to by First Ministers in September 2000. The work of officials on performance indicators has been collaborative and effective to date. Canadians will expect us to report on the full range of indicators by the agreed deadline of September 2002. While I am aware that some jurisdictions may not be able to fully report on all indicators in this timeframe, public accountability is an essential component of our effort to renew Canada's health care system. As such, it is very important that all jurisdictions work to report on the full range of indicators in subsequent reports.

In addition, I hope that all provincial and territorial governments will participate in and complete the joint review process agreed to by all Premiers who signed the Social Union Framework Agreement.

The *Canada Health Act* Dispute Avoidance and Resolution process outlined in this letter is simple and straightforward. Should adjustments be necessary in the future, I commit to review the process with you and other Provincial/Territorial Ministers of Health. By using this approach, we will demonstrate to Canadians that we are committed to strengthening and preserving medicare by preventing and resolving *Canada Health Act* disputes in a fair and timely manner.

Yours sincerely,

A. Anne McLellan

FACT SHEET: CANADA HEALTH ACT DISPUTE AVOIDANCE AND RESOLUTION PROCESS

Scope

The provisions described apply to the interpretation of the principles of the *Canada Health Act*.

Dispute Avoidance

To avoid and prevent disputes, governments will continue to:

- participate actively in ad hoc federal/provincial/territorial committees on *Canada Health Act* issues; and
- undertake government-to-government information exchange, discussions and clarification on issues as they arise.

Health Canada commits to provide advance assessments to any province or territory upon request.

Dispute Resolution

Where the dispute avoidance activities between the federal government and a provincial or territorial government prove unsuccessful, either Minister of Health involved may initiate dispute resolution by writing to his or her counterpart. Such a letter would describe the issue in dispute. If initiated, dispute resolution will precede any action taken under the non-compliance provisions of the Act.

As a first step, governments involved in the dispute will, within 60 days of the date of the letter initiating the process, jointly:

- collect and share all relevant facts;
- prepare a fact-finding report;
- negotiate to resolve the issue in dispute; and
- prepare a report on how the issue was resolved.

If however, there is no agreement on the facts, or if negotiations fail to resolve the issue, any Minister of Health involved in the dispute may initiate the process to refer the issue to a third party panel by writing to his or her counterpart.

- Within 30 days of the date of that letter, a panel will be struck. The panel will be composed of one provincial/territorial appointee and one federal appointee, who, together will select a chairperson.
- The panel will assess the issue in dispute in accordance with the provisions of the *Canada Health Act*, will undertake fact-finding and provide advice and recommendations.
- The panel will then report to the governments involved on the issue within 60 days of appointment.

The Minister of Health for Canada has the final authority to interpret and enforce the *Canada Health Act*. In deciding whether to invoke the non-compliance provisions of the Act, the Minister of Health for Canada will take the panel's report into consideration.

Public Reporting

Governments will report publicly on *Canada Health Act* dispute avoidance and resolution activities, including any panel report.

Review

Should adjustments be necessary in the future, the Minister of Health for Canada commits to review the process with Provincial and Territorial Ministers of Health.

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P.O. Box 5100
Fredericton, NB E3B 5G8
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NUNAVUT

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